			1- State of Maryland / Dep	artment of Health and i	Mental Hygie	2000 1115111
	Physici		Decedent's Name (First, Middle, Last)  Evelyn Lillian Sullivan		2. Date of Death Month May 25,	Day Year 2005 3. Time of Death
}	/Medic Examir		4a. Facility Name (If not institution, give street and number)  Madonna Heritage	4b. City, Town, or Location of Death  Jarrettsville		4c. County of Death Harford
	Funeral Director		5. Social Security Number 6. Sex $115-03-2161$ 6. Sex $1\square$ M $2\square$ F $3$ 7. Age (In yrs. last birthday 85 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.		
	Maryland a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L  Maryland Harford Joppa	ocation		10d. Inside City Limits 1 ☐ Yes 23 No
	th with the 23a or 28	ai Director	10e. Street and Number 221 Garnet Road	10f. Zip Code 21085	10g	. Citizen of What Country? USA
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-1 show aumatic event, I'm Medical Examinating the positive of the death.	by Funerai	11. Marital Status  1 Never Married 2 Married  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 ☒No Specify:	specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	d within 72 ho piene. r than "natur r a Medical	Completed	(Specify only highest grade completed) (Giville)  Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	rking	b. Kind of Business/Industry
and	d be filed antal Hyg ced other c event,	Be	17. Father's Name (First, Middle, Last)  Conrad (UNK) Moll		me (First, Middle, Ma. 1 (UNK) Clo	
Mary	es 1 and 2 should b of Health and Ment: f item 27 is marked r other traumatic e	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Ru	ural Route Number, C	ity or Town, State, Zip Code)
altimore, I	ages 1 and nt of Healt t: If item 2; / or other		20a. Method of Disposition 1	osition (Name of ematory or other place)	Date 20	c. Location - City or Town, State
Baltin	permit. Pages 1 Department of H Important: If ite any injury or ots 2005.		21. Signature of Funeral Service Licensee	Mem. Gardens: 5-2 2. Name and Address of Facility IcComas Funeral Ho 317 Cokesbury Roa	ome, P.A.	
8760, <	Physician and burial-transit is the burial-transit	dicai Examiner	23a. Part 1. Enter the disease or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):			Unser and Death
.O. Box 6	death certifi e attending id for use as	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
٥.	The law requires that the tee has been signed by thoage 2 should be detached.	by	Part II. Other significant conditions contributing to death but not resulting in the ATRIAL FIBRILLATION	underlying cause given in Part I.		cco use contribute to the cause of death?
of Vital Records,		Completed	HYPOTHYRUID ISM		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No
Division of Vita	tending Phy leath. tor: After this the funeral d	Certification: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 4 Homicide  28. Date of Injury (Month, Day Year)  28. Place of Injury - At home, Iarm, st building, etc. (Specify)	ont 3 DOA Other: 4 Nursing Hof 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how	et and Number or Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	a	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.			
	To thi within To the compli	Me	29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type WENOY ICCEST Codd Some Ites of TA  31. Date liled (Month, Day, Year)  32. Registrar's Signature  JUN 0 2 2005	29c. License number 7 31395	29d.	Date signed (Month, Day, Year)
	10		30. Name and address of person who completed cause of death (Item 23a) (Type WENDY ILLOESE, Cool Some Ites Pita	POB SUR 2081	2 5601 Lo	ich Rave Blad md 212
	Sta Registr	te ar	JUN 0 2 2005	e		

			for State Registrar	State of Maryla	nd / Dep <i>Ce</i>	artmen	t of H	ealth a Death	and M		giene	005	18502
	1		1. Decedent's Name (First, Middle, Last)							2. Date of De. Month		Year	3. Time of Death
	Physicia /Medic		BESSIE			CHULM	AN			MAY 31	L, 2005		9:10 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give s			4b. City,	Town, or	Location o			4c. Coun	ty of Death	
			3407 GLEN AVENUE		c loos historia	) If Under	1 Vear	BAL If Under 2	TIMO		th.	O Biah	N/A
	Funeral Director		5. Social Security Number 6. Sex 214-40-4411	IM 2 7. Age (In yr.	s. last birthday ? Yrs.	Months	Days	Hours	Min.	8. Date of Bin Month Da	1013	Gou	place (State or Foreign intry) MD
			Usual Residence of Decedent	X 3	-					002.0,			
	ylanc how		10a. State 10b. County		City, Town or L								10d. Inside City Limits
	Ba-fs	cto	MD N/	A	BAI	_TIMOR	E						1 X Yes 2 □ No
	or 20	Director	10e. Street and Number	- 10- 0		10f. Žip	Code	01.0			10g. Citizen of	f What Cou	•
	s 23e	Ta l	3407 GLEN AVENU		11.5	W D		212			14 Pc	an Amori	USA ican Indian,
	Item Item	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 🕅 No	0.5.	If Yes, spec	ify Cubar	n, Mexican	, Puerto I	cify Yes or No Rican, etc.)	BI	ack, White	, etc.
936	urs af	ρ	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	2X No	Specify:			Spec	ify:	WHITE
Ö	itied within 72 hours after death with the Maryland Hygiene ther than "natural", or Items 23a or 28a-f show ant, the Madical Examinational be collified at	Completed	15. Decedent's Educ (Specify only highest grade			e kind of wor			of working	20	16b. Kind of I	Business/Ir	ndustry
2	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT us	e retired)	)	O HOIN	,9	=======		
7	lygier her th	ပိ	4		I E	ACHER		40 11-15-	4- 11	/51 A A A	EDUCA		
and	I be fi	Be	17. Father's Name (First, Middle, Last)		1.0	COBSON		I DA		(FIIST, MIDDIO,	Maiden Suma		\PIRO
Ž	should be and Mental marked o	ဥ	MAX  19a. Informant's Name/Relationship (Type)	pe Print)						l Route Numbe	er, City or Town		
Š	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination in the routified at angle.	1	ALAN ABRAMOWITZ			D5 BAN							MD 21215
Baltimore,	f Healitern other		20a. Method of Disposition	20b	Place of Disp cemetery, cre	osition (Nan	ne of	NFR	TAMP	<del>1</del> 9)	20c. Location	- City or T	own, State
Ë	Pages nent of I int: If its iry or o		1 X Burial 2 ☐ Cremation 3 ☐ Re  4 ☐ Donation 5 ☐ Other (Specify)		UBAWIT						R0	SEDAL	E, MD
ati	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service License	90	7	22. Name an	d Addres	s of Facility	y S0	L LEVIN	ISON & J	BROS.	, INC.
<u> </u>	89 2 2 9		Koleto/c	hom									MD 21208
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the de ne cause on each line.	ath. Do not er	nter the mode	e of dying	g, such as	cardiac o	r respiratory ai	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	(	and	120	- /	1	ryt	timi;	2		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	quence of):	0		4	)				
	16.8.3	_	Sequentially list conditions, if any, leading to immediate	Due to (or as 1 suns	There	sel	no	in	_			-	
	nted Insit	Examiner	Cause (Disease or injury	P	to.	12	W 0 -						
Ć,	exection and and ial-tra	Еха	that initiated events resulting in death) Last	Due to (or as a cons	equence of):	100000	rvar	V-01					
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and to has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	cal		l,									
9	ng ph as th	Physician/Medical	IF FEMALE:										
Вох	eath certific attending p	lan/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	tal death 3	□Ectopic pr						ate of deliv	rery Day Year
<u>.</u>	the a	ysic	1 Yes 2 No	4 Pregnant at time of 9 Unknown	death 5	Other (sp.	ecity)						
۵.	that the di ed by the detached	Ph	Part II. Other significant conditions con	stributing to death but not re	sulting in the	underlying ca	ause give	en in Part I.		23e. Did to	obacco use co	ntribute to	the cause of death?
Vital Records,	uires tha signed Ild be det	d by								10	res 2 No	3 🗆 Pro	bably 4 Unknown
OS	w requir been si should	lete								24a. Was	an 24b	. Were aut	opsy findings available
Re	The la te has age 2	Completed								autor perfo	rmad? 22 No	prior to co death? 1 Yes	ompletion of cause of
ita	sician: The law s certificate has b irector, page 2 s	Bec	25. Was case referred to medical					26. Place	of Death	(Check only o		103	20.100
<u>-</u>	Physic this ce al direc	70	examiner?		☐ ER/Outpatie	ent 3 DO	)A Othe	er: 4 □ Nu	rsing Hor	ne 5 Ansid	dence 6 🗆 Ot	ther (Speci	fy)
פ	Attending Physician: r death. ector: After this certifica		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury		8c. Injury Work	at	1	8d. Describe I	now injury occu	urred	
200	tend death tor: /	icat	2 Accident investigation 3 Suicide 6 Could not be	One Place of Injury At	hama farm	M	1 🗆 Y	∕es 2 🔼		196 Logation (	Straat and Num	abor or Our	al Route Number,
Division of	I or Attendatter deatt Director:	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	nome, rarm, s cify)	treet, factory	, office		4	City or Tox	vn, State)	noer or Hur	ai Houle Number,
_	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 12 Certifying Phys	ician: To the best of my k	nowledge, dea	th occurred	at the tim	ie, date ani	d place, a	and due to the	cause(s) and n	nanner as s	stated.
	he Ho n 24 i he Fu	edical	(Check only 2 Medical Examination)	ner: On the basis of exami and manner stated.	nation and/or i	nvestigation,	, in my op	oinion, deal	th occurre	ed at the time,	date and place	, and due t	to the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier		3	290	. License			_	29d. Date sign		
	_		R. Toughama 1	L. 0 40	7		1)	20	15	8	06-	01-	-05
	18		30. Name and address of person who co	hpleted cause of death (It		, Print)	AA	0	-	171-			
†s	Sta	to	3640 T-0	32. Registrar's Sig		~I(	FV	''	.7	1215			
	Registr		JUN 0 2 2005		1 Col	uses							

			1 - For Stata Registrar	State of Maryland		artment of H		•	giene	005	18500
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Dath	Yeer	3. Time of Death
	/Medio		VERA D. SING 4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of D	Death	4c. Cou	2005 nty of Death	8.30 M
		Ci	NORTHWEST HOSPITAL	CENTER		RANDALL				TIMORE	
	Funeral Director		5. Social Security Number 6. Sex 1 1	7. Age (In yrs. In 90	ast birthday) Yrs.	Months Days		Hrs. 8. Date of Birt (Month, Da MAR. 27	h y, Yea <i>r)</i> 1015	9. Birthpl Count	ace (State or Foreign try) MD
	ъ		Usual Residence of Decedent	7 30	Town or La			I'MN • Z/	,1910		
	Maryla f shov	or	MD BALTIN		Town or Lo	GS MILLS				10	od. Inside City Limits 1 ☐ Yes 2 ☐ No
	th the or 28a.	Director	10e. Street and Number	IONE	ONTH	10f. Zip Code			10g. Citizen	of What Coun	try?
	s 23a	ral	4730 ATRIUM COURT	T #467 2. Was Decedent Ever in U.	3 40.1	Man Daniel of Hi	21117		14.5	Anna Anna da	USA
စ	after de or Item niner	Funeral	11. Marital Status 1 ☐ Never Married 2 💢 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		_		? (Specify Yes or No luerto Rican, etc.)		lace - America Black, White, e	atc.
21215-0036	be filed within 72 hours after death with the Maryland nial Hygiene. For other than "natural", or Items 23a or 28a-f show event, the Modical Examiner must be notified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		I□Yes 2M/No	Specify:			cify:	WHITE
75	nin 72 In "nat	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	lent's Usual Occupa kind of work done o DO NOT use retired	during most of	working	16b. Kind of	Business/Ind	ustry
	led with lygiene her tha	Com	12	College (1-401 34)	BOOK	KEEPER				EEPING	
Maryland	e d ala	To Be	17. Father's Name (First, Middle, Last) MORRIS		DANK	FR	18. Mother's	Name (First, Middle,	Maiden Surr	ame)	KALMAN
ary	2 should be and Mental Is marked caumatic ever	ř	19a. Informant's Name/Relationship (Typ	oe, Print)				r Rural Route Numbe	r, City or Tov	vn, State, Zip	
	B € 5 ₽		SAMUEL SINGER / H					467 - OWII		LS, MI	
mor	it. Pages rtment of I rtant: If It njury or o		1 X Burial 2 ☐ Cremation 3 ☐ Re  `4 ☐ Donation 5 ☐ Other (Specify)	SINOVALITORII STATE		sition (Name of natory or other plac NAH(AITZ	i			ETHORPE	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service License			. Name and Address		SOL LEVINS			
	80583		23a. Part1. Enter the disease, or complic	from J			ERSTOW	N ROAD - I	PIKESV	ILLE, N	ID 21208 Approximate
	Physician :		shock, or heart failure. List only one Immediate Cause (Final	e cause on each line.		1000 E00		440000	1631,		Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequ		HUEKE	DKHL	BLEED		-	
	LAdiminei	e e	Sequentially list conditions, b. if any, leading to immediate	. Due to (or as a consequ	ence of):						
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events								
760,	ate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consequ	ence of):						
89	tificate ig phys as the	ledic	d.								
Box	death certifica attending ph d for use as ti	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Bc. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnancy				Date of deliver	y Day Year
P.0.	the de by the a ached t	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐Unknown	ath 5L	Other (specify)					
	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by PI	Part II. Other significant conditions cont	tributing to death but not resu	lting in the ur	nderlying cause give	en in Part I.				e cause of death?
ord	w require been si	eted						-	es 2□No		/*
Division of Vital Records,	vysician: The lav nis certificate has director, page 2	Completed							sy rmed? 2 No	prior to con death?	sy findings available apletion of cause of
/ita	cian: ertifica ector, p	Be C	25. Was case referred to medical examiner?			Tal		Death (Check only o	ne)		/
of	Physi r this c ral dire	.: To	1 ☐ Yes 2 No Ho	28a. Date of Injury	R/Outpatien 28b. Time of	t 3 DOA Othe	er: 4 □ Nursir	ng Home 5 Resid			)
ion	tending Physeath. tor: After thi	atlor	1 Natural 5 Pending investigation	(Month, Day Year)	Injury	28c. Injury Work M 1 1	k? Yes 2 □ No				
ivis	or Atter or Atter or Director in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify)	me, farm, str	eet, factory, office		28f. Location (S City or Tow		mber or Rural	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to		29a. Certifier 1 Cartifying Physi	ician: To the best of my know	vledge, death	occurred at the tim	ne, date and p	lace, and due to the	ause(s) and	manner as sta	ited.
	the Ho hin 24 the Fu	Medical	one)	ar: On the basis of examinate and manner stated.	ion and/or inv						
	viit To		29b. Signature and title of certifier	Mehta mo	0	29c. License			Men 3	ned (Month, C	n P 5
	Ve		30. Name and address of person who cor				,	MEHTA	1	1	\ -
	,		31 Date filed (Month Day Year)	STAL CENTER	L R	MHORL	STOWN	d MO	21135	5.	
	Sta Registr		31. Date filed (Month, Day, Year) 2005	32. Registrar's Signat	A 224	W.					

			1 → For Registrar	State	of Man	yland / Dep <i>Ce</i>	artmer ertificat			ind Me	ental H	lygiei Reg.	21115	P. M. Albert	8504
			Decedent's Name (First, Middle, La	st)							2. Date of	Death			Time of Death
	Physicia /Medic		ZEYNOLD				TRA	VAL	ENA		Month		Day Yee	5	HI:01 AM
	Examin		4a. Fecility Name (If not institution, giv	e street and n	umber)	-			Location o				4c. County of De		
			JOHNS HOPK	いい	40 S	PITAL	BA	レナヤ	non	EC	ity		N	/A	
	Funeral		Social Security Number 6. S	ex Y∑M 2□F		In yrs. last birthday	) If Unde Months	1 Year Days	If Under 2 Hours	24 Hrs. (	8. Date of (Month,	Birth Day, Ye	ar) 9. B	irthplece ( Country)	State or Foreign
	Director		213-70-3271	<b>X</b> □W 2U F	4	9 Yrs.				1	May 1	4,19	56 M	aryla	ınd
	and *		Usual Residence of Decedent  10a. State 10b. County		1	Oc. City, Town or I	ocation							10d. In	side City Limits
	danyi f sho	5									_			1	☐Yes 2√ No
	the l	Director	Maryland Bal  10e. Street and Number	timore			10f. Zi	Code	M	lille	rs Is		t Citizen of What (	Country?	
	hours after death with the Maryland tursi', or Items 23a or 28e-1 show at Examiner must be notified at		2808 12th Stre	a+					21	219			United	,	-00
	heath ms 23	Funeral	11, Marital Status	12. Was De		er in U.S. 13	. Was Dece	dent of Hi	ispanic Orig n, Mexican		rify Yes or	No-	14. Race - An	nerican Inc	
0	or Iter		1 ☐ Never Married 2 ☑ Married	Amed F	2E No		_			, Puerto R	lican, etc.)		Black, Wh		
3	al', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or			1 🗆 Yes	2LXNo	Specify:				Specify:	Whit	e
215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural; or Items 23s or 28e-f show or other than "natural; or Items 23s or 28e-f show event, the Medical Examiner mant be notified at	Completed	15. Decedent's E (Specify only highest gra	ducation	0		edent's Usu		ation during most	of working	<u>-</u>	16b	. Kind of Busines	s/Industry	,
7	within 72 ene. than "na	npl	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT	se retired	)		3				
7	filed w Hygier ther th		12 Years			Tri	ıck Dı	iver			·5: . 14: /		Lowes		
/land	be filed htal Hygi of other event, I	Be	17. Father's Name (First, Middle, Last										den Sumame)		
	should be nd Menta marked imatic ev	To	Arthur Travalen		11 5 4	40. 44.		/2:			e D'E			** 0 /	
Mai	12 sh h and 7 Is n treun		19a. Informant's Name/Relationship ( Mrs. Madeline T										ty or Town, State nd . Mary		21219
	1 and Health em 2 ther t		20a. Method of Disposition	Lavarei		-				Da		_	Location - City of		
sairimore,	nt of I		1 ☑ Burial 2 ☐ Cremation 3 ☐		n State	20b. Place of Disp cemetery, cri			1						
	it. Partment		' 4 □ Donation 5 □ Other (Special Service Lice	- 1	1//	Oak Lav			y ↓u ss of Facility		,2005		Baltimo	ore,	Maryland
g	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked any injury or other treumatic evone.		In my	Ne	W	//   1	ouda-I	Ruck	Funer	al Ho				Inc. 2122	2
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that	caused the	e death. Do not e	nter the mo	de of dyin	g, such as	cardiac or	respirator	y arrest,	_	Inter	roximate val Between
	Pnysician		Immediate Cause (Final disease or condition	N	lur	IPLE S	ISTEN	0	n con	2	FAIL	UNE			et and Death
	/Medical		resulting in death)	Due to	or as a	consequence of):	1								
	Examiner		Sequentially list conditions.	b	SEF									20	166162
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			consequence of):								3.	いじもにら
	ecute and -trans	Examiner	that initiated events resulting in death) Last	C.		consequence of):	MIE	117657	רו מוז	7				2,	
8/60,	cate be executed physician and the burial-transit	cal E		Duett	o (or as a c	consequence or).									
œ		dic		_ d											
×	wrequires that the death certifi been signed by the attending should be detached for use as	/Me	IF FEMALE:	23c. If yes, o	utcome of	pregnancy							23d. Date of d	elivery	
X Q Q	atter I for u	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)	1 Live	birth 2	Fetal death 3	☐Ectopic p☐ Other (s						Month	Day	Year
j	the d by the	ysi	9 ☐ Unknown	9□ Unk	nown							_			
S,	requires that leen signed b hould be deta	by Pi	Part II. Other significant conditions	contributing to	death but i	not resulting in the	underlying	cause give	en in Part I.		23e. D	id tobacc	co use contribute	to the cau	use of death?
SD	quires n sign										11	☐ Yes	2 □ No 3 □	Probably	4 Unknown
Hecord	law rec as bee 2 shou	ompleted									24a. W		24b. Were	autopsy fir	ndings available
	o c o	шo									at pe	itopsy informed s 2 X	2 death	' ,	ion of cause of
VII	iicien: Th certificate rector, pag	Ö	25. Was case referred to medical						26 Place	of Death	1 ☐ Ye: (Check on:		No 1 □ Ye	s 215/1	NO
	ysicie s cer direct	0 B	examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1 2	Inpatient	2 ER/Outpatie	ent 3∏D	Othe					6 □Other (Sp	ecify)	
0	g Ph er thi	n: T	27. Manner of Death	28a. Date	e of Injury onth, Day Y	28b. Time		28c. Injun					njury occurred		
UNISION	ath. r: Aft	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation		inii, Day i	oa/ injury	М		Yes 2 1	No					
<u> </u>	r Atte	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	289. Plac	e of Injury	- At home, farm, s	treet, factor	y, office		28	8f. Location	n (Street Town, St	and Number or i	Rural Rou	te Number,
5	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certificy completely filled in by the funeral director,	Cer			3,	, -, -, -, -, -, -, -, -, -, -, -, -, -,									
	Hosp 4 hou Funel ely fil	edical	(Check only 2 Medical Example 1997)	niner: On the	basis of ea	my knowledge, dea xamination and/or									ause(s)
	the the the mplet	Med	one)	and ma	nner state	d.	- 1 20	o Linone	number			294	Date signed (Mo	nth Day	Vaar)
	To To	2	29b. Signature and title of certifier	a, M.	p.			c. License		. 45			Ay 31,	100 C	
,	1/							-c 5	-00	. 0		, , , ,			-
1	6		30. Name and add ss of person who			th (Item 23a) (Type LTH WOLF)		EET	Ba	rtimo	RE, N	TARY	AND 21	281	
	Sta	te	31. Date filed (Month, Day, Year)								•				
	Registr		JUN (	2 2005	Ho	s Signature	Apr	west !							

		For State Registrar		State of M	arylano / l		t of Health and e of Death		Reg. No.	2005	185
			ne (First, Middle, Las	t)				2. Date of Dea	ath	Vana	3. Time of De
sici		Anthony	,	Do	uglas		Taylor	Month	3 Day	2005	
	eal ier			street and number)		4b. City,	Town, or Location of Dea	th	4c.	County of Dea	ith
		Sinai Ho	ospital o	& Baitime	ore	Balt	imore City				
		5. Social Security N	Number 6. S		ge (In yrs. last bi	Months	1 Year If Under 24 Hr Days Hours Mir		/ Vaarl	9. Bir	rthplace (State or Fountry)
		220-64-	·8513	M 2□F	49	Yrs.	5.5,0	0'8 0		55	MD
		Usuel Residence of 10a. State	f Decedent 10b. County		10c. City, Tov	vn or Location					10d. Inside City
	ក	MD	NA			imore					1 X Yes 2
	ect	10e, Street and Nu			Daro	10f. Zip	Code		10g. Citi	zen of What C	ountry?
	ā						21207			U.S.A.	
	Funeral Director	6 Monne	ery Ct.	12. Was Decedent	Ever in U.S.	13. Was Dece	dent of Hispanic Origin? ( orly Cuban, Mexican, Pue	Specify Yes or No		14. Race - Am	erican Indian,
	필		ried 🌠 Married	Armed Forces? 1 ☐ Yes XX				rto Hican, etc.)		Black, Whi	ite, etc.
	b	3 🗆 Widowed	4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2  No Specify:			Specify:	Black
	Completed by	(Soe	15. Decedent's Ed	lucation	16a	. Decedent's Usu (Give kind of wo	al Occupation	orking	16b. Ki	nd of Business	s/Industry
	npie	Elementary/Seco		College (1-4or			rk done during most of w se retired)				
	Co	12th gr		na	A	ssitano	e Supervi			are Ho	ouse
	Be	17. Father's Name	(First, Middle, Last)					ame (First, Middle,		Sumame)	
	은		Justice					ne Good		T . 200.00	To Code !
			lame/Relationship (	WlI	e		(Street and Number or F				
				w Taylor			y Ct., Ba	Date		cation - City o	
		20a. Method of Dis 1 ☑ Burial 2	•	Removal from State		of Disposition (Na ery, crematory or c	1				
			5 Other (Specify		Mood	lawn Ce	metery 6/	3/05	Bal	timore	e Co, Mo
once.		21. Signature of F	al Service Licer	see	,		nd Address of Facility				
a		70	prelle	K- fm	6		Wabash Av			re, Mo	2121:
		23a. Part1. Enter shock, or hea	the disease, or com art failure. List only	olications Mat cause one cause on each l	d the death. Do ine.	not enter the mod	le of dying, such as cardi	ac or respiratory a	rest,		Interval Betwee
n.		Immediate Cause disease or condition	on	a. Non Sr	nall (e	11 Lung	cancer				TIYED
ai er		resulting in death)		Due to (or as	a consequence	of):					
•		Sequentially list co	onditions,	b. Due to for as	a consequence	of).					<del> </del>
Ī	ine	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease of the list is the list of	eriying	Due to (or as	a consequence	, 61).					
	Examiner	that initiated event resulting in death)		cDue to (or as	a consequence	of):					
	gi			d							
	Physician/Medical	IF FEMALE: 23b. Was deceder	at arosasat	23c. If yes, outcome						23d. Date of de	elivery
	ciar	in the past 12	2 months?		2 ☐ Fetal deat at time of death	h 3 ⊟Ectopic p 5 ☐ Other (s <sub>i</sub>				Month	Day Ye
	ysi	9 Unknown		9□ Unknown							
	i i	Part II. Other signi	ificant conditions	ontributing to death I	but not resulting	in the underlying	ause given in Part I.	23e. Did t	obacco i	use contribute	to the cause of dea
	Completed by	Tobacco	Abuse,	Brain Me	etastasi.	S		100	Yes 2	□No 3□F	Probably 4 Un
	lete		,					24a. Was		24b. Were a	autopsy findings av
	g.							auto	rmed?	prior to	completion of cau
		00 111					an Plans of P	1 Yes	2 No	1 🗆 Ye	s 2XNo
	) Be	25. Was case refe examiner?		Hospital:	iont a DEDIO	lutration 10 0	Other	eath (Check only of Home 5 Resi		6 Other (Sn	necify)
	1: To	1 Tes 2	No th	28a. Date of Inj	ient 2 ☐ ER/O ury 28b.	The second secon	28c. Injury at Work?	28d. Describe			y/
	tion	1 Natural 2 Accident	5 Pending investigation	(Month, Da	ay Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No				
	Certification;	3 🗌 Suicide	6 Could not be	28e. Place of In	jury - At home, 1	arm, street, factor	y, office	28f. Location (	Street ar	nd Number or F	Rural Route Numbe
	ert	4 Homicide	defermined	building, e	tc. (Specify)			City or To	wii, Stafe	7/	
		29a. Certifier	1 Certifying Ph	ysician: To the best	of my knowledg	ge, death occurred	at the time, date and pla	ce, and due to the	cause(s	and manner	as stated.
	Medical	(Check only one)	2 Medical Exam	niner: On the basis of and manner s	of examination a	nd/or investigation	, in my opinion, death oc	curred at the time,	date and	place, and du	ue to the cause(s)
	W	29b. Signature and	d title of certifier			29	c. License number		29d. Da	te signed (Moi	nth, Day, Year)
		19,00	ex more	may 1	00		RES-000	10	May	31,2	005
~		incl	// //	0	-	1					
~		30. Name and add	ress of person who	completed cause of	death (Item 23a)	(Type, Print)					
~			ress of person who Ziviama		death (Item 23a)	(Type, Print)	ital of Ba	Himore			

			1 - For State Registrar		aryland / De	partment Certificate			y 1000 -	Rag.	20	05	18506
	Physici	an	1. Decedent's Name (First, Middle, Last) RICHARD T		المالية				Mon	of Death th	Day 24	2005	3. Time of Death  7 45 pm
	/Medic Examin		4a. Fecility Name (If not institution, give			4b. City, To	own, or L	ocation of	Death Codo		4c. County		/ 1
				THE CON		16 Fus	STIN	6 AVE	= BALTO	MP 212	28		LTIMORE
	Funeral Director		210-42-07/1	7. Ag	e (In yrs. last birthd 61 Yrs	Months		If Under 2 Hours	Min. (Mor	of Birth th, Day, Yea 29, 1	943		ace (State or Foreign try) Land
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location						11	Od. Inside City Limits
	e Mary ta-f sh	ctor	MD		Baltimor	re							1 MYes 2 ☐ No
	h with th	Funeral Director	1820 Spence St., 2	Apt. 218		10f. Zip C	ode 2123	0		10g.	Citizen of V US	What Coun A	try?
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Items 23a or 28a-f show amy injury or othar traumatic evant, the Medical Evantinal restriction must be notified at angle.	by	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	Ever in U.S.	3. Was Decede If Yes, specify 1 \( \text{Yes} \) 2		anic Origi Mexican, Specify:	in? (Specify Yes Puerto Rican, e	or No-		ce - Americ ck, White, e y: Wh:	
21215-0036	within 72 hound. Ind. Ind. Indura	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(G lif	ecedent's Usual ive kind of work e. DO NOT use	Occupation done during retired)	on ring most	of working			usiness/Ind	
Q Q	filed v Hygie othar t	e Co	12 17. Father's Name (First, Middle, Last)		FC	reman	1	8. Mother	's Name (First, I	_		uctic	on
/lan	utd be Wental Irked o	To Be	George Toplanchik					Dolo	res Broo	ks			
Maryland	nd 2 sho alth and l 27 is ma ir trauma		19a. Informant's Name/Relationship (Ty. Steven Toplanchik	pe, Print)		-			or Rural Route eet, Bal			-	
Baltimore,	ages 1 a ant of Hea it: If itam y or otha	1	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Di cemetery, Baltimo	crematory or other	er place)		Date 5/31/05			City or To	wn, State
Baltir	permit. F Departme Importar any Injur		21. Signature of Funeral Service Lic-15	- 1/2 -	. 6	22. Name and ary L.	Address Kauf	of Facility Man I	Funeral	Home @	Mead	lowrid	lge MP, Inc.
8760, <	The law requires that the death certificate be executed THM I have been signed by the attending physician and THM I have been signed by the detached for use as the burial-transit I have been signed by the detached for use as the burial-transit I have been signed by the detached for use as the burial-transit I have been signed by the burial-transit I have burial-t	dical Examiner	23a. Part 1. Enter the dispase, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause Final II deathing Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as	a consequence of): a consequence of):	enter the mode				tory arrest,	<del>Je, r</del> .		Approximate Interval Between Onset and Death
.O. Box 6	that the death certific ed by the attending p detached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	3c. If yes, outcome 1∐Live birth 4∐Pregnant at 9∐Unknown	2 Fetal death	3 □Ectopic preg 5 □ Other (spec				_		te of deliver	ry Day Year
rds, P.	quires that n signed b	þ	Part II. Other significant conditions cor	ntributing to death b	ut not resulting in th	e underlying cau	ise given	in Part I.	23e	. Did tobacc 1 ☐ Yes			e cause of death?
Reco	he law requir e has been si age 2 should I	Completed		green opp	onia				_	Was an autopsy performed	·	prior to com death?	sy findings available apletion of cause of
ta	lan: T	Be C	25. Was case referred to medical	910			2	6. Place o	of Death (Check		No	1 Yes	2 L No
Division of Vital Record	or Attanding Physician: The law after death. Biter this cartificate has t Director: After this cartificate has t in by the funeral director, page 2 s	은	examiner?  1 Yes 2 NA Pending  27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	lospital: 1 ☐ Inpatie 28a. Date of Inju (Month, Da			Other: c. Injury at Work? 1  Yes	4 Librars		Residence			)
Divis		Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubul	ury - At home, farm, c. (Specify)	street, factory, o	office		28f. Loca City	tion (Street or Town, Sta	and Numb	er or Rural	Route Number,
	To tha Hospital or within 24 hours afte To tha Funeral Diracompletely filled in the	edical	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☐ Medical Examir	sician: To the best of ner: On the basis of and manner sta	examination and/or	eath occurred at r investigation, in	the time, n my opin	date and ion, death	place, and due to occurred at the	o the cause time, date a	(s) and ma	inner as sta and due to	ited. the cause(s)
	To tha within 2 To tha complet	×	29b. Signature and title of certifier	fug.	Hendy	29c. l	D3	6 9	142	29d. 0	Date signed	2.5	2005
	1		30. Name and address of person who co	mpleted cause of d	eath (Item 23a) (Typ	De, Print)	Ro	R	ALTIN	wr c	, M	, 2	1228
	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signature	dicarte)	,						

			For State Registrar	State of		ınd / Dep		t of H	ealth a		lental Hy	giene		
							runcai	e or L	Jeani			Reg. No.	4445	1-0507
ı	Physici /Medic		Decedent's Name (First, Middle, Howard Worth		ster						2. Date of De Month May	ath Day 28	2005	3. Tímb of/Déath /
	Examin	_	4a. Facility Name (If not institution,	give street and num	ber)		4b. City,	Town, or	Location of	of Death		4c.	County of Dear	th
			Lorien Nursing	Center-Co	lumbi	a		olum				Ho	oward	
	Funeral Director		219-18-6287	4 C 44 6 C 5	7. Age ( <i>lin yi</i> 80	s. last birthday Yrs.	Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da June 9	y, Year)		thplace (State or Foreign ountry)
	and w		Usual Residence of Decedent  10a. State 10b. County		10c.	City, Town or L	ocation							10d. Inside City Limits
	Maryli f sho	ō	Md Carrol	.1	S	ykesvil	le							1 ☐ Yes 2 ☐ No
	286-	Director	10e. Street and Number			-	10f. Zip	Code				10g. Citi	zen of What Co	ountry?
	3a or		605 Fannie Do	rsey Road			21	784				US	SA	
و	be filed within 72 hours after death with the Maryland Hygiene. A the Hygiene. do ther than "naturel", or items 23a or 28e-f show event, the Medical Examinal must be natified at	/ Funeral	11. Marital Status  1 🗆 Never Married 2 📆 Marrie	12. Was Dece Armed For 1 Tyes If Yes, Give	ces? 2 ∐ No	U.S. 13.	Was Deced tf Yes, spec		spanic Origin, Mexican	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)		14. Race - Ame Black, Whit	te, etc.
ğ	ure!,	d by	3 Widowed 4 Divorced	Year or Da	tes:								WI	hite
<u>.</u>	"nat	Completed	15. Decedent' (Specify only highest			(Giv	edent's Usua e kind of wo DO NOT us	rk done a	lurina mosi	t of worki	ing	16b. Ki	nd of Business	/Industry
2	within	шć	Elementary/Secondary (0-12)	College (1-	4or 5+)		engin		,			NAS	SA	
2	filed Hygin other ent, I		17. Father's Name (First, Middle, L				8		18. Mothe	r's Name	(First, Middle	Maiden	Sumame)	
an	should be nd Mental marked c metic ev	To Be	Elmer Worthing	ton Webst	er				Pea	rl M	ae Weld	h		
Maryland 21215-0036	d 2 should th and Men 7 is marke treumetic	-	19a. Informant's Name/Relationsh				•						r Town, State, 2	. ,
	C = 01 L		Mrs. Gloria Web	ster (spo	···					Rd.,	Sykesy	ille	e, Md 21	1784
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3. □Removal from 9	20b	. Place of Disp cemetery, cre	osition (Nar ematory or o	ne of ther place	9)		Date	20c. Lo	cation - City or	Town, State
Ĕ	Pages ment of I ent: If it ury or o		`4 □ Donation 5 □ Other (Sp			eadowri	dge M	emor	ial 6	-2-0	5	E1kr	idge. N	4d
Baltimore,	permit. Pag Department Importent: It any injury o		21. Signature of Funerat Service L  Paige Haige	ht Herb	lut	P	2. Name ar	d Addres	s of Facilit	<sup>y</sup> Hai kesv	ght Fur ille, M	eral	Home &	& Chapel
г	11 7		23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that ca	used the de									Approximate Interval Between
- 1	Trysician		Immediate Cause (Final disease or condition resulting in death)			equence of):								Month
	/Medical Examiner		,	Due to (	or as a cons	equence of):	10-	, D G	. г	715	DAIF			2020 1 To
14		er	Sequentially list conditions, if any, leading to immediate	b. Due to (c	or as a cons	equence of):	M	, .	7 (	٠.٠	4.50			moneto
	d d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			SRIEN								YEARS
ó	ate be executed nysician and he burial-transit		resulting in death) Last			equence of):								
3760	ate be hysici he bu	Ical		d										
× 68	The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as the	by Physician/Med	IF FEMALE:	23c. If yes, outo	nme of orec	inancy						II.	20.4 Date of dat	P
P.O. Box	atten for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bi	rth 2 ☐ Fe	etal death 3	□Ectopic pr						3d. Date of del Month	Day Year
o	the d y the	lysl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unkno										
Ţ	requires that the di been signed by the should be detached	y Pł	Part It. Other significant condition	ns contributing to de	ath but not r	esulting in the	underlying c	ause give	n in Part I.		23e. Did t	obacco u	se contribute to	the cause of death?
Records,	quires n sign uld be	q pe									10	/es 2[	⊇No 3⊟Pr	robably 4 Unknown
ပ္သ	aw re s bee 2 sho	Completed									24a. Was		24b. Were au	utopsy findings available completion of cause of
ř	The lavite has	E O										rmed?	death?	2 No
Vital	Physician: The la rithis certificate hai and director, page 2	Bec	25. Was case referred to medical						26. Place	of Death	(Check only o			
> <u>-</u>	nysic nis ce I direc	To	examiner?	Hospitat. 1 ☐ Ir	patient 2	☐ ER/Outpatie	nt 3 DC	Othe	Nu De Nu	rsing Ho	me 5 Resi	dence 6	Other (Spe	cify)
Division of	ding Pl h. After th funeral		27. Manner of Death Natural 5 Pending	28a. Date o (Monti	f tnjury n, <i>Day Year)</i>	28b. Time of this		8c. Injury Work	at		28d. Describe			
20	tendi leath. tor: A the fu	catl	2 Accident investig	ot he			М		/es 2 □ !			2		
2	or At after of Direct in by	Certification:	4 Homicide determin	and 288. Place	g, etc. <i>(Spe</i>	home, farm, si cify)	reet, factory	/, office			City or To			ural Route Number,
_	To the Hospitel or Attending Physician: within 24 hours alter death To the Funerel Director: After this certifica completely filled in by the funeral director,		(Check only 2 Medicet E	Physicien: To the exeminer: On the ba	sis of exami									
	the the mplet	Medical	one) 29b. Signature and title of certifier	and mann	er stated.			. License					e signed (Mont	
	S Z Kil			. ND										
			opupa	(IAI)		00-\ C**	De De	005	> 315	0		~ H	1 312	2005
	t.		30. Name and address of person was Sharun Mar	mo completed cause	of death (II A Or	6m 23a) (Type	, Print) D	A G	0 6	206	50 H) (1	TE	NRIA	21045
	Sta	te						· · · · · ·					1 Theres	
	Registr		JUN 0 2	2005		E								
DHN	H 17 Rev 1/2	001		2003	Musica			)						
						ORIGIN	AI							

Walter Wintsch 05-03740 RPD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. nend item#27, perME, C844, 6/3/05 TT

	_	Hogistial ACTUALD TIEFT	#7&8 PER I	NF G84	46	10675	3 TH	Jeath			Reg. No.	- C.		10000
<b>Physiciar</b>	n	1. Decedent's Name (First, Middle, Last	t).						Ì	2. Oate of De Month	ath Day	, Y	'ear	3. Time of Death
/Medica	al -	Walter Frederick		Sr.						May 3		005		1409 P
Examine	r	4a. Facility Name (If not institution, give				4b. City, T			of Death		4c.	County of	Death	
uneral		St. Agnes Hospita  5. Social Security Number 6. Se		(In yrs. last b	oirthday)	Balt If Under		'e If Under	24 Hrs.	8. Dete of Bir	th11_7	n/a 21_10	<b>Def</b> reth pl	ace (State or Forei
irector		088-18-6901	<sup>™ 2□ F</sup> -83	- 80	Yrs.	Months	Days	Hours	Min.	Month, Da	y <del>, Y6</del> ar) <del>'</del>   4 19	11 1).	Zouni N.J	
3:44	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	neation							140	d. Inside City Limi
1 sho	. 1	MD Baltimor		-	oniu								1	1 □ Yes 2 1 ☑ N
288-	Funeral Director	10e. Street and Number		1 1111	Oma	10f. Zip (	Code				10g. Citiz	zen of Wha	at Count	
38 01	<u> </u>	114 E. Padonia R	d.			21	1093					USA		•
swe start	ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13.			spanic Ori	igin? (Spe	cify Yes or No Rican, etc.)		14. Race -	America White, e	
or it	Dy Fu	1 Never Married 2 Married	Yes 2 No	43-'46		1 ☐ Yes 2	_	Specify:		noan, oto.,		Specify:	white, e	
tural al Ex	Q Da	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu				dent's Usual		tion						
n"na fedic	plet	(Specify only highest grad	de completed)		(Give	kind of work DO NOT use	k done d	u <i>ring</i> mos	t of workir	ng	160. Kir	nd of Busir	10SS/ING	ustry
other than ent, the M	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Mana	ager					Tra	avele	rs I	nsurance
# E	Re C	17. Father's Name (First, Middle, Last)								(First, Middle,	Maiden :	Sumame)		
marked o	0	John Wintsch								ggman				
7 is me traums		19a. Informant's Name/Relationship (T) Ethel Wintsch/wife	,, ,			-				I Route Numbe imoniu				Code)
item 27 is marke other traumatic	-	20a. Method of Disposition		20b. Place	of Dispo	sition (Name	e of	1	D	ate		cation - Cit		vn. State
important: If iten any injury or oth		1 Marial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)				matory or oth	•	·	6/4/					AD 21093
/ inju	Ì	21. Signature of Funeral Service Licens	600		22	2. Name and	Addres	s of Facilit	ty					
any ir		Michael J. Fla 23a. Part1. Enter the disease, or comp	agle			emmo	n Fu Pad	inera Ionia	B Ho	me of	Dula	ney	Valle	ey, Inc.
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DHMH 17 Rev 1/2001

ORIGINAL

05-3739 B.K.S MARKIA WISE

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Description   Provided   Description   Des	WISE		State of Maryland / De 1- State Amend Item 1&Unpend Item 23a&2	partment of Health and Me per me 6846 8-18-0 entificate of Death	•	
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24a. Was an autopsy prior to completion of cause death of the part	caminer	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
24a. Was an autopsy prior to completion of cause death of the part	od by the attending phys detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	5 Other (specify)	23a Did toha	Month Day Year
25. Was case referred to medical examiner?   12. West	ite has been signed by the attending phoage 2 should be detached for use as the	d by		ordanying cause given in raiti,		E.A.
25. Was case referred to medical aximiner?    Y   Yes   2   No	e has bee	mplete			autopsy performe	
27. Manner of Death 1			25. Was case referred to medical	Of Blace of Death /		□No 11 Nes 2 No
27. Manner of Death 1	s cert lirect	o B	examiner?	Othor		es C MOther (Caseful
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ARCA ACCOUNTS 11 Penn Street Baltimore, Maryland 21201	h. After this funeral o		27. Manner of Death 1 Avatural 5 Pending 28a. Date of Injury (Month, Day Year) Injur	of 28c. Injury at 28 Work?		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ARCA ACCOUNTS 11 Penn Street Baltimore, Maryland 21201	after death. I Director: A d in by the fu	ertifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,		f. Location (Stree City or Town,	et and Number or Rural Route Number, State)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ARCA ACCOUNTS 11 Penn Street Baltimore, Maryland 21201	e Funerei letely filled		(Check only 2 Medicel Examiner: On the basis of examination and/or	eath occurred at the time, date and place, and investigation, in my opinion, death occurred	d due to the cau	se(s) and manner as stated. e and place, and due to the cause(s)
30 Name and address of person who completed cause of death (Item 23a) (Type, Print)  ARCA ACCOUNTS 111 Penn Street Baltimore, Maryland 21201	within 24 hours afte To the Funerel Dir. completely filled in I	Me	29b. Signature and title of certifier		29d	I. Date signed (Month, Day, Year)
Park La Acquira - Collak wo 111 Penn Street Baltimore, Maryland 21201	10		Yatru Granica-Tolle	OCME		2007
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	11-		30 Name and address of person who completed cause of death (Item 23a) (Type AAC (AAAC)	111 Penn Street	Baltimo	re, Maryland 21201
	Stat	te	31. Date filed (Month, Day, Year)  32. Registrar's Signature 200			

			1 - For State Registrar	State of Ma	arylan		artment tificate			and M		Reg.	20	05	18510
	Physici /Medic		1. Decedent's Name (First, Middle, Last, Helen R. Williams	)							2. Date of Month May		Day 2005	Yeer	3. Time of Death 4:40P M
	Examir		4a. Facility Name (If not institution, give		•		-		Location of	of Death			4c. County		
	Funeral		4413 Haverford Dr 5. Social Security Number 6. Se		(In yrs. I	ast birthday)	Ro-	ckvi 1 Year_	11e If Under	24 Hrs.	8. Date of	Birth		t gome	ry place (State or Foreign ntry)
	Director			]M 2∭ F	76	Yrs.	Months	Days	Hours	Min.	Jan.	Day, Ye	1929	Conn	ecticut
	and w		Usual Residence of Decedent  10a, State 10b, County		10c. City	, Town or Lo	cation								10d. Inside City Limits
	Maryli f sho	lor	Maryland Montgomer	rv		kville									1 ☐ Yes 2 🔀 No
	r 28a	Director	10e. Street and Number	- J		ICV III C	10f. Zip	Code				10g.	Citizen of	What Cou	ntry?
	23a c		4413 Haverford Dr	ive			208	853				Un	ited	State	es
036	d within 72 hours after death with the Maryland Jiene. Jiene. r than "natural", or Items 23a or 28a-1 show the Medical Examinar must be indiffied at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 XN If Yes, Give Year or Dates:		1	Was Decedor f Yes, special I Yes 2		spanic Ori n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or Rican, etc.)	No-	Bla	ce-Americk, White,	
Maryland 21215-0036	n 72 ho	Completed	15. Decedent's Edu (Specify only highest grad			16a. Deced	lent's Usual kind of worl DO NOT use	k done a	lurina mos	t of worki	ing	16b	. Kind of B	usiness/Ir	dustry
212	d within giene. ir than "	ome	Elementary/Secondary (0-12)	College (1-4or 5- 2	+)		tered						Hospi	tal	
pu	be filed that Hygie of other avant, II	Bec	17. Father's Name (First, Middle, Last)								First, Mid	dle, Mai	den Sumar	пө)	
yla		To	Kostas Eliopolous								njick				
Mai	s 1 and 2 should f Health and Mer itam 27 Is marke other traumatic		19a. Informant's Name/Relationship (Ty James A. Williams/								al Route Nu		-		-
ē,	s 1 and 2 of Health a itam 27 Is other trau		20a. Method of Disposition		20b. PI	lace of Dispo	sition (Nam	e of		une	, Boy o	200	. Location	- City or To	
E C			t XBurial 2 ☐ Cremation 3 ☐ F  * 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State		keview	-			200		Br Cc	idgep	ort,	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	<sub>ее</sub> мо135	53	Ro Ro	Name and Ckvil Ckvil	Addres 1e, 1e,	inc. Inc. Mary	, Rob 300 1and	West 2085	Pur Mon 0-28	mphre tgome 05	y Fur ry Av	neral Home/ venue
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Respirat  Due to (or as a	ory a consequ	Failur		of dying	, such as	cardiac c	or respirator	y arrest,			Approximate Interval Between Onset and Death
8760,	death certificate be executed eathending physician and tor use as the burial-transit	ledicai Examiner	if any, leading to immediate  Cause (Disease or injury	Ovarian  Due to (or as a Due to (or as a d.	a consequ	ence of):									
.O. Box 6	death certiti e attending I od tor use as	hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 Fetal	death 3	Ectopic pre							te of delive	ery Day Year
rds, P	signed signed d be de	by P	Part II. Other significant conditions con	ntributing to death bu	t not resu	ilting in the ur	iderlying ca	use give	n in Part I.						ne cause of death?
Vital Record	The law ate has b page 2 sl	Completed									24a. W au pe 1 🗆 Ye	itopsy informed	?	Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of 2 No
Vita	Physician: Th this certiticate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:				Otha			(Check on				
o	ding h. After fune	ation; To	1 Yes 2 XNo  27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	1 ☐ Inpatier 28a. Date of Injun (Month, Day	v	ER/Outpatien 28b. Time of Injury		c. Injury Work	at	2	me 5 🗓 Re 28d. Descrit				y)
Division	Direction	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc.	ry - At ho . (Specify	me, farm, stre	eet, factory,	office		2		n (Street Town, St		er or Rura	il Route Number,
	4 th	edical	29a. Certifier 1	sician: To the best oner: On the basis of and manner state	examinati	wledge, death ion and/or inv	occurred a estigation,	t the time in my op	e, date and inion, deat	d place, a	and due to to ed at the tim	he cause ie, date	e(s) and ma and place,	anner as s and due to	tated. the cause(s)
	To the l	Me	29b. Signature and title of certifier	_			29c.	License	number			29d.	Date signe	d (Month,	Day, Year)
•	7		1 Jan /	2			47	612	MD			Jı	ine I	, 200	5
1	0		30. Name and address of person who co					,,	/1/				_		
	Sta	te	Paul J. MacKoul, M 31. Date filed (Month, Day, Year)	3 Registra	r's Signat	ure A	Avenu	e,#	414,	Beth	iesda,	Mar	cyland	1 20	814
	Registr		JUN 0 2 200		, St.	ure Jos	A.S.								

				For State of N	laryland /			ealth and M	lental Hyg	jiene	
				Registrar		Certific	cate of E	<i>Jeath</i>		leg. No.	
_		Physici /Medic		1. Decedent's Name (First, Middle, Last)  Donald Eugene Wol	fe, Sr.				2. Date of Dea Month May 26	Day Year	3 Time of Death   22:41 M
		Examin		4a. Facility Name (If not institution, give street and number				Location of Death		4c. County of De	ath
				Upper Chesapeake Medical			el Air	Militardos (14 Hrs		Harford	
	Ľ	Funeral Director		214-24 <b>-</b> 3053	ge (In yrs. last i	Yrs. Mon	nder 1 Year hths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March	11, 1927	irthplace (State or Foreign Sountry) Virginia
		and and		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location	1				10d. Inside City Limits
		death with the Maryland ms 23a or 28e-f show	tor	Maryland Harford	Aber	rdeen					1 ☐ Yes 2 ZNo
		r 28e	Director	10e. Street and Number			f. Zip Code		1	log. Citizen of What (	Country?
		th wit		1823 Tower Road			21001			USA	
		tems	Funeral	11. Marital Status 12. Was Deceder Armed Forces	? \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	13. Was D	ecedent of His specify Cubar	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	
	36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates	INO TZ	4 🗆 🗸	es 2 No	Specify:		Specify:	
	21215-0036	filed within 72 hours after death w Hygiane, other than "netural", or items 23a ont, the Mydical Exacting Cast I		<ol><li>Decedent's Education</li></ol>	Korea Vietnan	n Decedent's	Usual Occupa	tion		16b. Kind of Busines	White s/Industry
33:4	215	hin 72	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-40)	(5+)	(Give kind o	of work done d OT use retired)	ition uring most of worki	ng		•
3	21	er the	Com	9		wner/ (	Operato	or		Restauran	t/ Bar
0	pu	be file tal Hy d oth	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Name		•	
	yla	Men Men Marke Marke	P		olfe			Margie	Eunio		
2	Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiens. Internal, or items 23a or 28e-f show Important: If item 27 is marked other than "netural, or items 23a or 28e-f show any injury or other traumatic event. The Mudical Extra interfer and be notified at any injury or other traumatic event. The Mudical Extra interfer and be notified at any injury or other traumatic event.		19a. Informant's Name/Relationship (Type, Print)  Clara Wolfe - Wife		_				r, City or Town, State, ryland 210	
5/3/0/6/5	é,	1 and Healt Herm 2		20a. Method of Disposition	20b. Place	of Disposition	(Name of	! 0	-	20c. Location - City of	
9	<u></u>	ages ant of it: If it		1√2 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	9	tery, crematory		ns   6/01	/05	Bel Air, M	aruland
10	Hir	artme ortan injur		21. Signature of Funeral Service Licensee	Det F		ne and Address			Funeral Ho	
100	ä	Depar Depar Impor any ir		Male T- 22		131	7 Cokes				land 21009
		7.		23a. Part1. Enter the distase. Complications that caus shock, or heart failure. List only one cause on each	ed the death. D	o not enter the	mode of dying	, such as cardiac o	r respiratory arr	rest,	Approximate Interval Between
4		Priysician		Immediate Cause (Final disease or condition		LL C	ELL C	PRCINE	MA	LUNG-	Onset and Death
		/Medical Examiner			s a consequenc				,		
		LAdimilei	<u>.</u>	Sequentially list conditions, b.	s a nonsequenc	m offs					
	J	led Isit	Examiner	Sequentially list conditions, if any, loading to instructions, cause. Enter Underlying Cause (Disease or injury that initiated events	a a nonaequeno	se our					
$\overline{\odot}$	v 	and and al-tran	xar	that initiated events c. resulting in death) Last Due to (or a	s a consequenc	ce of):					
3510	68760,	icate be executed physician and s the burial-transit		d.							
F		± 0 %	edical							-10	
0	Вох	eath certific attending p for use as	Physician/M	IF FEMALE: 23c. If yes, outcom	e of pregnancy 2 Petal dea		oic pregnancy			23d. Date of d	,
#	Э.	ne deat the att	sicia	1 Yes 2 No	at time of death		or (specify)			Month	Day Year
9	P.O.	that the de ed by the detached	Phy	9 Unknown	h			- in Powl	22 - Did to		to the server of death?
8	S,	se, ugu	by	Part II. Other significant conditions contributing to death					23e. Did to		to the cause of death?  Probably 4 Unknown
	cords,	w requires been sign should be	Completed	DIABERS 1							
-	Rec	2 2 2	mpl	prince its in	rezer	100	<u> </u>		24a. Was a autops perfori	sy prior to med? 24b. Were a prior to death?	autopsy findings available completion of cause of
21		sicien: The lav certificate has rector, page 2	e Co	25. Was case referred to medical				00.01	1 ☐ Yes		s 2 No
(2)	Vita	Physicien: this certific al director,	o Be	examiner?  1 Yes 2 Peno Hospital: 1 Penpa	tient 2□EB/	Outpatient 3	T DOA Othe	26. Place of Death		ence 6 □Other (Sp	ecify)
0	1 0	ding Phys n. After this funeral di	$\vdash$	27. Manner of Death 28a. Date of In		o. Time of Injury	28c. Injury Work			ow injury occurred	
بلس)	io	Attending r death. ector: Alter by the fune	atlo	2 Accident investigation	ay row)	М		es 2□No			
4	Division	or Atterderiter de Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of I building,	njury - At home, etc. (Specify)	farm, street, fa	ictory, office		28f. Location (Si City or Town	treet and Number or I n, State)	Rural Route Number,
0		ital o									
Molfe, Pan		To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier 112 Certifying Physician: To the best (Check only one) 2 Medical Examiner: On the basis and manner and manner	of examination						
		To the within 2 To the complet	Me	20h Signature and title of partition			29c. License	number	2	9d. Date signed (Mor	nth, Day, Year)
4			ļ	Hulm Nowal	enst	1' 141	Do	809	6	MAY 2	7,2005
		1581	And the second	30. Name and address of person who completed cause of	death (Item 23a	a) (Type, Print)	125	N. MAII	V ST	1302-A11	P. MD2/019
		Sta Registr			trar's Signature		)				

		1. Decedent's Name (First, Middle				artment of rtificate	01 00	ш,		. Date of Dea	ath		3. Time of Deat
Physicia /Medic		Jessamyn A	Amber Wenne	ell						Month May	$28^{\text{Day}}$	2005	0746
Examin		4a. Facility Name (If not institution,	, give street and num	iber)		4b. City, Tow	vn, or Loca	ation of D	eath		4c. Cou	inty of Death	
		Carroll Hospita			-	Westm						roll	
uneral irector		5. Social Security Number 216–71–5399	6. Sex 7 1 M 2	7. Age (In yrs. la	est birthday) Yrs.	Months Da		Under 24 I ours N	frs. 8	Date of Birth (Month, Day OV •	4,2004	9. Birthp Coun Mary	lace (State or Fore Ity) Land
<b>3</b> III		Usual Residence of Decedent  10a, State  10b. County		10c, City.	, Town or Lo	ocation						1	0d. Inside City Lim
f sho	5	Maryland Carro	11	1	anches							,	1 ☐ Yes 2 ☐
or 28a-f show be notified at	Director	10e. Street and Number 3816 Miller	es Station	Rd.		10f. Zip Coo	de 102				10g. Citizen	of What Coun	
rust be	eral	11. Marital Status		dent Ever in U.S	13			oio Origina	/Specif	Vac or No	14.5	Race - Americ	
or Iten	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Ford	ces? 2 ∰ No e		Was Decedent If Yes, specify ( 1 ☐ Yes 2 🛱		exican, Po pecify:	ierto Ric	an, etc.)		Black, White,	
atural', cal Exp		15. Decedent	's Education			dent's Usual Oc					16b. Kind o	f Business/Inc	dustry
d other than "n event, I're Medi	Completed	(Specify only highes	College (1-	4or 5+)	(Give life.	kind of work do DO NOT use re	one during etired)	g most of	working				,
	To Be C	17. Father's Name (First, Middle, L John R. Wenn					E .			First, Middle, Glassi		name)	
item 27 is marked of other traumatic eve		19a. Informant's Name/Relationsh Jennifer Wennel		r	19b. Mailir 3816	ng Address (St	reet and N	Vum <i>ber or</i> ation	Rural F	loute Numbe Mancl	r, City or Too	wn, State, Zip	Code) 21102
Important: If item 27 any injury or other tra		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp.		tate COI	ace of Dispo metery, crei	osition (Name of matory or other urch Cen	of place)	Ī	Date		20c. Locatio	on - City or To	wn, State
Importan any injur		21. Signature of Funeral Service L		221103		Name and Ackhardt 296 Cha:		1	•			*	
/sician ledical aminer		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	and mu	ch line	Do not ent	er the mode of	dying, suc	ich as card	diac or re	espiratory arr	rest,		Approximate Interval Between Onset and Death
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Exa	mine	4a. Facility Name (If not institution CARROLL HOSP	-	imber) NTER			or Location of D		4c. Co	CARRC	)LL
Fune		5. Social Security Number 220-52-4463	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. 55	last birthday) Yrs.	If Under 1 Yea Months Days		Min. (Month, Da	th ay, Year)		place (State or Foreign ntry)
Direct	or	Usual Residence of Decedent		33				12/14	/194	9 MARY	LAND
arylan show	١,	10a. State 10b. County			ty, Town or Lo					1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
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should ind Men a marke	F	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Address (Stree		r Rural Route Numb			
or E, INC ss 1 and 2 of Health a litem 27 la		KATHY BEACHA	M - SIS		_		M DR.,	WESTMIN	STER	, MD.	21157
Pages 1 nent of He int: If iter		20a. Method of Disposition 1 ☐ Burial 2X Cremation	3 ☐Removal from	State	cemetery, crer	sition (Name of natory or other pl	· 1	Date		tion - City or To	
		*4 □ Donation 5 □ Other (\$ 21. Signatur of Fuperal Service	Specify)	AĻL				5/14/05			E, MD.
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p37		23a. Part1. Enler the disease, o shock, or heart failure. Lis	r complications that only one cause on	caused the deat	th. Do not ent	er the mode of dy	ring, such as care	diac or respiratory a	rrest,		Approximate Interval Between
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To the Hospital or Attending Phyalcian: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely tilled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	3 Suicide 6 Could 4 Homicide determ	sined 289. Place	of Injury - At he	ome, farm, str by)	eet, factory, office	•	28f. Location (: City or Tox	Street and N vn, State)	lumber or Rura	l Route Number,
pital o	٥		a Physician: To th	a hast of my kno	and death	annumed at the	lime date and al	lace, and due to the	201100(0) 20	d manager as at	
ne Hos n 24 h ne Fun	odical	(Check only 2 Medical one)	Examiner: On the t	pasis of examina iner stated.	ition and/or in	estigation, in my	opinion, death o	occurred at the time,	date and pla	ace, and due to	the cause(s)
To the Within To the Comp	Ž	29b. Signature and title of certifie	1	DOM	-11 +	29c. Licer	nse number	0	29d. Date s	igned (Month	Day, Year)
WJL	-	Clabe	t Vuc	icus	141)	D 5	5727	6	2	115/0	
3		30. Name and address of person  R. Rickett	who completed cau	se of death (Item Lest v	n 23a) (Турө, ИИЅ 🗡	Print) 4/C	2115	7	3617	e /	
	State	31. Date filed (Month, Day, Year,		Regionar's Signa							
Reg	istrar	MAY.	L 7 2005	July	N.	Breeke					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 10:40 AM 2005 ma) Otha Ray Brown /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Union Memorial Hospital Baltimore Baltimore City If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 M 2□ F Yrs. 90 Director 188-09-5056 Nov. 4, 1914 Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show r than "natural", or iteme 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 XNo Director Franklin Waynesboro 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 13673 Harbaugh Church Rd. 17268 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White þ Specify: 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Iron Worker Refrigeration 6 marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other treumatic event Be Otha E. Brown Lucinda P. Masters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn R. Kline (Daughter) 12441 Wolfsville Rd. Myersville, Md. 21773 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) June 2 Rest Haven Cemetery 2005 Hagerstown, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. 21783 Enter the disease, or complications that caused or heart failure. List only one cause on each lin complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between and Death Immediate Cause (Final disease or condition Physician shock /Medical resulting in death) as a consequence of): Due to (or **Examiner** Sequentially list conditions Examiner a consequence of day leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed use as the burial-transit wan disease peripheral the attending physician and resulting in death) Last a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? has this certificate 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2XNo Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death 28b. Time of Certification: After Natural 5 Pending М 1 Tyes 2 □ No investigation Director: filled in by the 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funerel Dire Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AT2438946 may 28, 2005 cause of death (Item 23a) (Type, Print) Angela mislowsky East University Parkway Bathmore, mp 21218 31. Date filed (Month, Day, Year)
JUN 0 2 2005 32. Registrar's Signature State Registrar

			1 = For State Registrar	State of Maryla		artment of H			ene 2005	18515
	.Physic		Decedent's Neme (First, Middle, Last     Lind	) la M. Bagley				2. Date of Death May 1	3 <sup>ay</sup> 2005	3. Time of Death 2:04 P M
	Examir		4a. Fecility Name (If not institution, give Morningside House	, ,		Elli∞t	Location of Death		4c. County of Deeth	
	Funeral Director		5. Social Security Number 6. Se 561 03 8929  Usual Residence of Decedent	7. Age (In yrs	s. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		place (Stete or Foreign ntry) ria
	72 hours after death with the Maryland netural', or Items 23a or 28a-f ehow disal Exacta net must be tradified at	al Director	10a. State 10b. County  MD Howard  10e. Street and Number  4474 Columbia Roa	I	Ellicot			10g	. Citizen of What Cou	
9000-	72 hours after dea "netural", or Items disal Exament	ted by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Edu			Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ∑No dent's Usual Occupa	Specify:		14. Race - Americ Black, White,  Specify:  William Specify:	etc. hite
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Maryland	Mental Mental arkad c	To Be	17. Father's Name (First, Middle, Last)  George Malouf  19a. Informant's Name/Relationship (Ty	vaa Printl	10h Mailie		La Biba M			
Baltimore, Ma	jes 1 and 2 of Health a if item 27 is		Patricia B. Houck.  20a. Method of Disposition  1 Burial 2 Cremation 3 F  1 Donation 5 Other (Specify)	/Daughter 20b.	4474	Columbia sition (Name of natory or other place	Road Ell	Licott Cit	ity or Town, State, Zip W. MD 2104 c. Location - City or To atonsville	42 own, State
Baltii	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service Licens		.044	. Name and Addres	s of Facility Hai	ry H. Wit		ily FH Inc.
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Division of Vital Record	ding Phys n. After this funeral di	Certification: To Bo	examiner?	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work M 1 \( \triangle Y	T 4 □ Nursing Ho at ? 'es 2 □ No	28d. Describe how i	njury occurred	asst. livg
Ö	pital or Attenous after deatl		4 Homicide determined	28e. Place of Injury - At I building, etc. (Speci	( <b>'</b> y')			City or Town, Si		
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Signature and title of canfier	sician: To the best of my kn ter: On the basis of examin and manner stated.	owiedge, death ation and/or inv	29c. License	inion, death occur	red at the time, date	and place, and due to  Date signed (Month, L	the cause(s) Day, Year)
			30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type, )			· Clarks	May 17, 2 wille M	005 D 21039
	Sta Registr		31. Date filed (Month, Day, Year). MAY 1 9 21	32. Risgistrar's Sign	atura					

			1 - For State Registrar	State of Marylar		artment of rtificate o			giene 005	18516
	Physici /Medi	cal	Decedent's Name (First, Middle, Last)     CHARLIE     4a. Facility Name (If not institution, give state)	HENRY BUI	LLOCK	4h City Town	, or Location of D	2, Date of Dea Month MAY	Day Year  13, 2005  4c. County of Deat	3. Time of Death
	Examir Funeral	ier	Casey House 5. Social Security Number 6. Security N		last birthday) Yrs.		ckville	е	MONTG	
	Director	tor	238-24-7743   X-	10c. Ci	ty, Town or Lo	ermant	own	Sept.	11,191/ N	10d. Inside City Limits 1
	th with the 23e or 28e	Funeral Director	10e. Street and Number 11200 Dunsta	ble Way		10f. Zip Code	208	}	10g. Citizen of What Co	•
036	ours after dea al', or items Examinat m	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1∑Yes 2 ☐ No If Yes, Give Year or Dates: 42 —		Was Decedent of If Yes, specify Co		? (Specify Yes or No- uerto Rican, etc.)		
21215-0	I within 72 ho iene. rthen "netur the Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 7th	cation e co <i>mpleted)</i> College (1-4or 5+)	(Give	DO NOT use reti	e during most of		16b. Kind of Business/	,
yland 2	outd be filed   Mental Hyg   warked other	To Be C	17. Father's Name (First, Middle, Last)  Charlie D. Bi				18. Mother's	Name (First, Middle, Llian Kit	Maiden Sumame) ctrell	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "netural; or items 23e or 28e-f show amounts injury or other treumatic event. The Medical Examinar must be notified at ODGE.		19a. Informant's Name/Relationship (Ty)  Lila Bullock (\( \)  20a. Method of Disposition  \( \)	Wife)  emoval from State  20b. F	1120 Place of Dispo cemetery, cren	O Duns sition (Name of natory or other p	table V	May, Gern	n, City or Town, State, Z nantown, M 20c. Location - City or T	4D 20876
Baltim	permit. Pag Department Importent: any injury once.		'4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	MD	22		ress of Facility		Crownsvil FUNERAL HO Eville, MI	ME, P.A.
	Pnysician /Medical		23a. Part 1. Enter the disease or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the deat le cause on each line.  Adult f  Due to (or as a conseq	ailur			diac or respiratory an	rest,	Approximate Interval Between Onset and Death
8760,	cate be executed by sician and the burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	wence of):					
O. Box 6	death certifi e attending p d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3□	Ectopic pregnar Other (specify)			23d. Date of delin Month	very Day Year
rds, P.	The law requires that the tee bas been signed by the base should be detached.	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	nderlying cause (	jiven in Part I.		bacco use contribute lo es 2. No 3 ☐ Pro	
Vital Records,		Completed						24a. Was a autops perform	sy prior to co	opsy findings available ompletion of cause of
Division of Vit	ding Phys h. After this funeral di	ation; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	ospital: 1  Inpatient 2  28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. In	ther: 4 🗆 Nursin		ence 6 <b>2</b> ther (Speci ow injury occurred	<sub>M</sub> Hospice
DIVIS	spitel or Atten ours after deat nerel Director: filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	y) 			City or Town	·	
	To the Hospitel within 24 hours a To the Funerel completely filled	Medicai	one)	ician: To the best of my kno ler: On the basis of examina and manner stated.	wledge, death tion and/or inv	estigation, in my	opinion, death o	ccurred at the time, d	ate and place, and due t	to the cause(s)
	N WIT		30. Name and address of person with con			Print)	112	18	9d. Date signed (Month, $5/17/6$ ) ockville,	25
	Sta Registr		Charles Harris 31. Date filed (Month, Day, Year) MAY 1 8 2005	2. Registrar's Signa			er wit.	ra., R	JUNITIE,	10.0000

			1 - For State Registrar AMEND#12perINF5	State of Maryland		artment of				11111	18517
	Dhysisi		Decedent's Name (First, Middle, Last)	719/03,EW,P00		imodio or	Douin	2. D	Reg. Pate of Death Month	Day Year	3. Time of Death
	Physici /Medio	al		shaw, Jr.				Ma	ay 1	2 2005	
4	Examir	er	4a. Fecility Name (If not institution, give st 12125 Remington D	•		4b. City, Town,				4c. County of Dea	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I.		If Under 1 Year Months Days			ate of Birth Month, Day, Ye	Montgo 9. Bi	mery  thplace (State or Foreign ountry)
	Director		578-22-8068 Usual Residence of Decedent	83	Yrs.		110010		g.10,19		hington,DC
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	8e-fs	ctor	Maryland Montgome	ry Si	lver S						1 ☐ Yes 2 ☑ No
	with the	Funeral Director	10e. Street and Number			10f. Zip Code 2090	2		10g.	Citizen of What C	ountry?
	death ms 23	era	12125 Remington D  11. Marital Status	2 Was Decedent Ever in LL	S. 13. \	Was Decedent of f Yes, specify Cut		gin? (Specify )	Yes or No-	USA 14. Race - Am	erican Indian,
36	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be molified at once.	y Fur	1 Never Married 2 Married	Armed Forces? 1942-1 1 ⊠Yes 2 □ No If Yes, Give	-510	f Yes, specify Cut 1 □ Yes 252 No		i, Puerto Ricar	n, etc.)	Black, Wh	te, etc.
5-0036	tural Ex	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educ	If Yes, Give Year or Dates: Unknow		dent's Usual Occu			161	. Kind of Business	White
215	thin 72 9. nn "ne Medik	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most	t of working	100	. Italia of Dasilles	unidustry
2121	led wit ygjen ygjen yer th	Con		5+	Phys	ician				Medic	al
and	d be fi	Ве	17. Father's Name (First, Middle, Last)						it, Middle, Mai		
Maryland	should and Me mark umatic	To	Raymond Bradshar  19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Address (Stree	t and Numbe	ary M. er or Rural Rou	Riddle ite Number, Ci	ty or Town, State,	Zip Code)
	end 2 salth a n 27 is		Nancy J. Bradshaw		12125	Remingt	on Dr	ive Si	llver S	pring,Md	20902
Baltimore,	Pages 1 nent of He int: If iten		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Re	moval from State 20b. PI	ace of Dispo emetery, cren	sition (Name of natory or other pla	ice)	May Date	13, 200	. Location - City of	
Itim	artmen artmen ortant: injury		* 4 □ Donation 5 □ Other (Specify)  21. Signature 11 Februar Service □ Service	Met	ropoli	tan Crem	natory	2005	A1	exandria	Virginia
Ba	Deptimber		I Kollet /	Spai	Fr	ancis J.	Coll csity	ins Fur Blvd	neral H	ome, Inc Spring,M	D 20901
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death						27.4.6311	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Chronic Rena	1 Fail	ure					Onset and Death  5 years
	/Medical Examiner			Due to (or as a consequ		1					
		Jer	Sequentially list conditions, any lacing to include the cause. Enter Underlying Cause (Disease or injury	Generalized  Due to lor as a consult	Athero unce of):	sclerosi	LS				20 years
	acuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last								
8760,	ate be executed hysician and the burial-transit		resulting in death) cast	Due to (or as a consequ	ence of):						
687	ificate g phys as the	edic	d.								
Вох	eath certific attending p I for use as I	an/M	230. Was decedent pregnant	c. If yes, outcome of pregnar 1□Live birth 2□Fetal		Ectopic pregnanc	ev.			23d. Date of de	*
.O.	The law requires that the death certificate be executed to has been signed by the attending physician and sage 2 should be detached for use as the burral-transit	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐Unknown		Other (specify)	,			Month	Day Year
۵.	that the ned by detac		Part II. Other significant conditions conti	ributing to death but not resu	Iting in the ur	nderlying cause gr	ven in Part I.	2	3e. Did tobacc	o use contribute to	the cause of death?
Vital Records,	w requires been sign should be	ed by	Chronic Obstruct:	ive Pulmonary	Disea	se			1 <b>∳</b> Yes	2 □ No 3 □ P	robably 4 Unknown
ecc	e law re has be	Completed						2	4a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
al B								1	performed ☐ Yes 2 🔀	? death?	
Z:	5 6 E	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	spital: 1 ☐ Inpatient 2 ☐ E	D/Outset	Ott		of Death Che		- TO:: /a	
J of			27. Manner of Death		28b. Time of Injury	t 3□ DOA 28c. Inju Wo	ry at		escribe how in	6 □Other (Spe	city)
Sior	Attending r death. ector: After by the fune	catic	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(World, Buy Your)	mjury		Yes 2 N				
Division	i Di aft o	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, stre	et, lactory, office		28f. Lc	ocation (Street ity or Town, St	and Number or Ri ate)	ural Route Number,
	ours ours berai		29a. Certifier 1 Certifying Physic	cian: To the best of my know	vledge, death	occurred at the ti	me, date and	d place, and du	e to the cause	(s) and manner as	s stated.
	within 24 h	ledical	Uney	er: On the basis of examination and manner stated.	on and/or inv			h occurred at t			
		Σ	29b. Signature and title of certifier	mantan	tini	29c. Licens			29d.	Date signed (Mont	h, Day, Year)
	10		30. Name and address of person who com	pleted cause of death (Item	23a) (Tyne F	D 121	21		Ma	ay 12, 20	005
_			George F. Sengstack	c, M.D. 3929	Ferra	ra Drive	Whea	aton,Ma	ryland	20906-47	09
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 8 2005	Registrar's Signatu	ure Ann	K)			-		
	ricgisti	-11	11111 7 0 5000	MOSING NO.	19	- AT 1					

State of Maryland / Department of Health and Mental Hygiene UU5 1- State Registra-AMEND#29dperMD5/20/05, BMW, MoCertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day George F. Banks 16, 2005 May 10:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sunrise Assisted Living Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) Feb. 27, 1916 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Davs Hours 89 578-09-4005 Yrs Tennessee Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28e-f show 10d. Inside City Limits the Medical Examiner must be notified at 1X Yes 2 □ No Mary1and Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23e permit. Pages 1 and 2 should be filed within 72 hours atter death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Items 23e eny injury on their treumatic event. The Medical Examiner must once. 11621 New Hampshire Avenue #208 20910 United States Funerai Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: Negro 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher D.C. Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Banks Oberlin Reid 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7116 Alaska Ave. N.W., Washington, D.C. Alana B. Smith 20012 / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 5/23/05 \* 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Suitland, MD 22. Name and Address of Facility McGuire Funeral Service 21. Signatur of Funeral Service Licensee hompson 7400 Georgia Ave. N.W., Wash. D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ventricular Arrythmia /Medical Due to (or as a consequence of): **Examiner** Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Coronary Artery Disease Due to (or as a consequence of): Box 68760. Diabetes Mellitus IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No 1 ☐ Yes 1 Yes 2**X** No director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\boxtimes$ Other (Specify)Assist. Certification; To 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 XNatural 5 Pending after death. investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 2 one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nasreen Kango, M.D. 7610 Carroll Ave. Suite 205, Takoma Park,/MD 20912 31. Date filed (Month, Day, Year) MAY 1 8 2005

Registrar DHMH 17 Rev 1/2001 Registrar's Signature

Amended It. 23 part II and It. 27 per MD. It.31 & It.32 per CCHD, am 5/24/2005 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician Carol Ann Bartlett May 2005 2:25A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll 8. Date of Birth (Month, Day, Year)
Dec. 8, 1937 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1□M 2**X**F Hours Months Days Min. 216-11-9561 67 Director England Usual Residence of Decedent filed within 72 hours after death with the Maryland show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Maryland Baltimore Director 1 ☐ Yes 2 🔀 No Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 7912 Vernon Ave. or Items 23a 21236 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Yes. Give Specify: by 3 Widowed 4 □ Divorced Specify: White Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other treumatic event, Ita M College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Jeffrey Ellen Kaye ဂ္ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Nelson/ daughter 7912 Vernon Ave. Baltimore, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If eny injury or once. All County Cremation <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 5/9/2005 Sykesville, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Licens 310 Church St. New Windsor, MD 21776 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Pnysician Congestive heart failure year /Medical Due to (or as a consequence of): Examiner Cirrhosis liver 1 year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Mitral regurgitation 1 ☐ Yes 2 No 3 Probably 4 Unknown Chronic aspiration Terminal Aspiration 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes 25. Was case referred to medical examiner?

1 . Yes 2 . XNo 26. Place of Death | Check online) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 🗷 EP/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 X Natural 5 Pending investigation after death. within 24 hours after death To the Funerel Director: / completely filled in by the f 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) D38915 May 8, 2005 気か use of death (Item 23a) (Type, Print) Khalil Freiji 295 Stoner Ave. Westminster, MD 21157

31. Date filed (Month, Day, Year) State

32. Registrar's Signature

MAY 9 2005

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Frances O. Coghill ΑM May 11 2005 8:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Nursing & Rehab. Center Clinton Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. Yrs. Director 579-38-4383 76 28, Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked othar than "natural", or Itams 23a or 28a-f shoi traumatic event, ire Medical Examiner must be netflied at 1X Yes 2 No Directo Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9211 Stuart Lane 20735 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ If Yes, Give Year or Dates: **Black** 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) is 1 and 2 should be filed with the sith and Mental Hygien tam 27 is marked othar th 12th Administrative Officer Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence W. Obie, Sr. Mary Susan Fields 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 is 5902 Justina Drive, Lanham, MD Marsha Washington - Daughter 20706 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ō 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Department Important: If \* 4 □ Donation 5 □ Other (Specify) Quantico National Cem. 5/18/2005 Triangle, VA 22. Name and Address of Facility Stewart Funeral Home 21. Signative of Fulleral Service Licensee 4001 Benning Rd., N.E. Wash., DC 20019 ther the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in with) Frysician End stage renal disease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or when) Due to (or as a consequence of): Examine Hospital or Attanding Physician: The law requires that the death certificate be executed physician and the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. I 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ò 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2. No 2□ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Certification: To Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death.

Funaral Diractor: A investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ane us D35206 May 11, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 William T. Tanner, M.D. 11701 Livingston Rd., #101; Ft. Wash., MD 31. Date filed (Month, Day, Year) Registrar's Signature State MAY 1 9 2005 Registrar

	-		1- State of Maryland	-	artment tificate			ind M	F	eg. No. 0	15	18521
	Physic /Medi Examii	cal	Decedent's Name (First, Middle, Last)     Donald Baldwin Case     4a. Facility Name (If not institution, give street and number)	∍y	4b. City, 7	own, or	Location o	f Death	2. Date of Dea Month May	Day	Year 2005 of Death	3. Time of Death
	Funeral		10 Circle Drive  5. Social Security Number 6. Sex 7. Age (In yrs. I. 337-24-4066 1⊠ M 2□F 77	ast birthday) Yrs.	If Under		rt De If Under 2 Hours	4	8. Date of Birth (Month, Day NOV 2	Year)	Ceci	l place (State or Foreign http) Illinois
	Director 28a-f show	tor	Usual Residence of Decedent	, Town or Lo		ort	Depo	sit	Nov. 2	7,1927		.TIINOIS  10d. Inside City Limits  1 ☐ Yes 2 ☒ No
	ath with the 23a or 28a	Funeral Director	10e. Street and Number 10 Circle Drive		10f. Zip (	Code 2	1904				J.S.A	
9600	is 1 and 2 should be filled within 72 hours after death with the Maryland if Health and Mantal Hygiene. Item 27 is marked other than "natural", or Itama 23a or 28a-f show other traumatic event, the Medical Exercities must be conflicted at	þ	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S Armed Forces?  1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 1947	'-67 <sup>1</sup>	I□Yes 2	X No	Specify:	jin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	Specif	ck, White,	White
121215-0036	lad within 72 lygiene. her than "nat	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  Twelve Years	16a. Deced (Give life. L	kind of worl DO NOT use	done di retired)	uring most			U.S. 2	Army	dustry
Maryland	12 should ba filad within h and Mantal Hygiene. 7 Is marked other than "raumatic event, Its Mar	To Be	17. Father's Name (First, Middle, Last) Frank Casey  19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address			0	(First, Middle, i Llie Ba] Il Route Number	.dwin		o Code)
altimore, M	0 0		1 23 Dunai 2 Doreniation 3 Direntoval nom State	ace of Dispos	sition (Name natory or oth	of er place	)	С		20c. Location -	City or To	
Baltir	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee	Le Pe	Name and ee A. erryvi	Address Patt	of Facility erso Mar	n & ylan	Son Funda 2190	eral Ho 3-0766		eryland
8/60,	whysician and hysician and the buriat-transit	edicai Examiner	23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the consequ	rence of):  3- 1244  rence of):		Um		is the		751,		Approximate Interval Between Onset and Death
C. BOX 6	The law requires that the death certificate be executed to has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 🗌	Ectopic pre Other (spe						te of delive	ery Day Year
ords, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resu	Iting in the un	derlying car	ise giver	n in Part I.			oacco use cont	ribute to the	cause of death?
or Vital Records,		e Completed	25. Was case referred to medical				26 Place	of Death	24a. Was a autops perform 1 Yes 2	y ned? d !⊠No 1	orior to coi death?	psy findings available npletion of cause of 2 [] No
Ion or v	ing Phys After this uneral di	atlon: To B		ER/Outpatient 28b. Time of Injury		Cther Linjury : Work?	4 □ Nur	sing Hon	ne 5 🔀 Reside	nce 6 🗆 Oth		1)
Division		il Certification;	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At hor building, etc. (Specify)	)					City or Town	, State)		l Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one)  1	on and/or inve	estigation, in	the time in my opi License	nion, death	occurre	d at the time, da	ause(s) and ma ate and place, a od. Date signed	and due to	the cause(s)
	Gri/YI		30. Name and address of person who completed cause of death (Item	5.	Print)	n	Ave		H106	Mb	21	078
	Sta Registr		31. Date filed (Month) Day, Year)  MAY 2 0 2005	ILO								

			1 - For State Registrar	State of Mary	•	artment of I		•	Reg. No	2005	18522
	Physici /Medio Examir	al	Decedent's Name (First, Middle, L. William     A. Facility Name (If not institution, gi	Henry	Conno		or Location of Dea		Da 15,	y Year 2005 . County of Death	3. Time of Death 10:43 a M
	Funeral Director		212-64-6304	Sex 7. Age (In	n yrs. last birthday) 52 Yrs.	Germa If Under 1 Year Months Days	if Under 24 Hours Mi	n. (Month, Da	rth ay, Year)	Montgomery  9. Birth Cor  1952 Pen	nplace (State or Foreign Intry) nsylvania
21215-0036	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury opether traumatic event, the Medical Example traumatic and once.	completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  10e. Street and Number  2923 Faulkner  11. Marital Status  1 Never Married  3 Widowed 4 Provorced  (Specify only highest gr  Elementary/Secondary (0-12)	Place  12. Was Decedent Eve Armed Forces? 1	r in U.S. 13.	Sington  10f. Zip Code 208  Was Decedent of If Yes, specify Cub 1 Yes 2 No  dent's Usual Occup kind of work done DO NOT use retire at e Troop	Hispanic Origin? an, Mexican, Pue Specify: cation during most of w		16b. K	14. Race - Amer Black, White	USA ican Indian, , etc. ite
Baltimore, Maryland	permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any injury of either traumatic event once.	To Be (	17. Father's Name (First, Middle, Las Henry William (19a. Informant's Name/Relationship Carole Ann Conno 20a. Method of Disposition ↑ Burial 2 □ Cremation 3 (10 □ Cremation 5 □ Other (Spec. 21. Signature of Funeral Service Lice	Connor, Jr. (Type, Print) Or/ Sister  Removal from State	292 20b. Place of Dispo cemetery, crei Gate of Hea	ven Cemete Name and Addre	Dorot  and Number or I  er Place  co) Ma  ry 2  ess of Facility Collins	Date y 21, 2005 Funeral	ne Go ner, City on 1gtor 20c. Lo Silv	ortschal orTown, State, Zon, MD 20 ocation-City or T orer Springer Inc.	ip Code) 895
8760,	The law requires that the death certificate be executed by the attending physicien and unique to should be detached for use as the burial-transit	licai Examiner	23a. Part. Enter the disease, of conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  S. Juential y list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	pilications that caused the rone cause on each line.  a. Cardiac Due to (or as a complete to the complete to t	Arrhythmi onsequence of): Cerebell onsequence of):	a		ac or respiratory a	rrest,		Approximate Interval Batween Onset and Death  Years
O. Box 6	that the death certific ted by the attending p detached for use as I	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnanc	у			23d. Date of deliv Month	rery Day Year
S, D	w requires that i been signed by should be deta	þ	Part II. Other significant conditions Hypotension	contributing to death but no	ot resulting in the u	nderlying cause giv	ven in Part I.		obacco ( Yes 2	_	the cause of death?
ital Rec		Be Completed	25. Was case referred to medical				26. Place of De	24a. Was autopendo 1 Yes	psy prmed? 2K No	24b. Were autroprior to condeath?	opsy findings available ompletion of cause of
Division of Vital Record	or Attending Physicien: after death. Director: After this certifici in by the funeral director.	Certification; To E	examiner?  1 Yes No  27. Manner of Death  1 No  2 Accident  3 Suicide 6 Could not 1	28a. Date of Injury (Month, Day Ye	At home, farm, str	28c. Injur Wor M 1		Home 5 Resi	how injur Street an	y occurred  d Number or Rur	Residence
ρίς	To the Hospital or Attending Ph within 24 hours after death.  To the Funerel Director: After th completely filled in by the funeral	Medical Certi	29a. Certifier 1X Certifying P	hysician: To the best of m miner: On the basis of exand manner stated.	Specify)  y knowledge, death	occurred at the til	ppinion, death occ se number	City or Too	cause(s) date and	and manner as s I place, and due t se signed (Month,	stated. o the cause(s)  Day, Year)
	\ O		30. Name and address of person who Jose De Leon Car 31. Date filed (Month, Day, Year)	pio, M.D. 2	0407 Sen	eca Meado	D58844 Dws Pkwy	, German	May town		376
	Registr	ar	MAY 1 8 20	10 Been .	15. May 10						

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death E U 3. Time of Death **Physician** May 13, 2005 2018 James Melvin Conley /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carroll 659 Whispering Meadows Ct. Westminster If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, **Funeral** Days Hours Min. 1⊠M 2□F Yrs. Director 214-44-9951 59 Aug 21, 1945 Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f ahow the Medical Example; must be notified at 1XXYes 2 □ No Maryland Carroll Westminster Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 659 Whispering Meadows Ct. 21158 USA Funeral filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify þ 3 ☐ Widowed 4 € Divorced White Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

| Compared to the 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Auto Mechanic Firestone 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles K. Conley Helen Shifflette 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau 659 Whispering Meadows Ct. Westminster, MD 21158 James K. Conley Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1√2 Burial 2 ☐ Cremation 3 🗷 Removal from State Dyke, Virginia 4 Donation 5 Dother (Specify) Mt. Olivet Cemetery 5/17/2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21157 412 Washington Rd. Westminster. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hebatiti vears /Medical Due to (or as a consequence of) Examiner ohs:3 the liver years of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as a dansadilionda of The law requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-Physiclan/Medical attending for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) the per 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy perform certificate 2. No 1 🗌 Yes 2□ No 1 Yes 25. Was case referred to medical examiner?
Yes 2 □ No director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Sesidence 6 Other (Specify) 2 ER/Outpatient 2 1 Inpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: Injury at Work? After or Attending Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie May 14,2005 P0051924 30. Name and address of person who completed cause of death/lem 23a) (Type, Print)
Herbert P. Henclerson 51. MN 2973 Manchester RJ Manchester MD 21102 32. Regionar's Signature State Elven & Sparke

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

2005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** May 15, 2005 Scott Linwood Collins 0908 /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Malcolm Grow Medical Center Prince George's Camp Springs If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 ★ M 2 ☐ F 7. Age (In yrs. lest birthday) **Funeral** Deys 26, Director 1955 Maryland 217-68-9437 Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland D. partment of Health end Mental Hygiene. In contant: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evanded must be notified. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No Upper Marlboro Directo Prince George's Maryland 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 20772 United States 9711 Marlboro Pike Funeral Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 N No tf Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Saltimore, Maryland 21215-0020 à 3 ☐ Widowed 4 ☐ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Service Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Blanche Louise Willett Paul Jacob Collins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10524 Deacon Rd., White Plains, MD 20695 Blanche Collins-mother 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05-20-2005 Waldorf, MD Trinity Memorial Gdns. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses M01246 Huntt Funeral Home 3035 Old Washington Rd., Waldorf, Maryland Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed the attending physician end hed for use es tha bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): 23b. Did tobacco use contribute to the ceuse of deeth? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ P/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 □ Yes this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Deat 1 Vaturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No deeth. investigation I Director: A 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours To the Funeral [ Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.

| Provided Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Dey, Yeer) 29b. Signature end title of cartifier 30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

MAY 19

2005

32. Registrar's Signeture

05-03297 Katherine Davis RJD

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

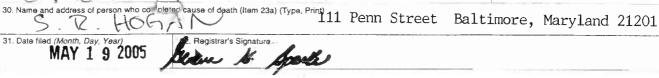
State of Maryland / Department of Health and Mental Hygiene 2015

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- 1	1.7	5.7	1	

		Registrar		Cer	Tificate of	Dealli	F	Reg. No.		1006
		1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea	ath		3. Time of Death
Physic		Katherine Da	vic				May 12	<b>, 28</b> 05	Year	1128A.
/Medi Examir		4a. Facility Name (If not institution, give			4b. City. Town.	or Location of Death		4c. County	of Death	
Exami	iei	Prince Georges H		ntor						
		5. Social Security Number 6. S			Cheverl		100	Princ		
Funeral		1	M 2 □ X F 7. Ag	e (In yrs. last birthday)  F Yrs.	Months Days		8. Date of Birth (Month, Day	n /, Year)	9. Birthp	place (State or Foreigntry)
Director		578-64-0256		55_ ''s.			Dec. 4,	1949	Was	sh., DC
p .		Usual Residence of Decedent  10a. State 10b. County		100 Cit. T						
aryla shor	_	Tob. Southy		10c. City, Town or Lo	cation				1	IOd. Inside City Limit
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Ę <b>8</b>	- e	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?
38 o	0	6606 Cro	ig St., #:	301	9	20743		T7	+ - J C	States
ns 2	Funeral I	11. Marital Status	12. Was Decedent				nacity Vas or No-		e - Americ	States
itan Itan	Ë		Armed Forces?	l l	f Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	o Rican, etc.)	Bla	ck, White,	etc.
or	by F	1 Never Married 2 Married	1 ☐ Yes 2 🔀 If Yes, Give	NO .	1 ☐ Yes 2 ☑ No	Specify:		Specif	, Afr	cican
Ja Ja	d b	3 Widowed 4 Divorced	Year or Dates:							erican
72 hours after death with the Maryland natural', or Itams 23a or 28a-f show diest Examiner must be porified at	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Deced	tent's Usual Occup	pation during most of wor	kina	16b. Kind of B	usiness/In	dustry
within ene.	q	Elementary/Secondary (0-12)	College (1-4or 5	life. I	DO NOT use retire	nd)	9			
a filed within al Hygiene. I other than '	P.O.	12th	3- (	·	cretary-	Registra	r	D.C	Puhli	c Schools
filed Hygi other ant,	0	17. Father's Name (First, Middle, Last)			crecary.		ne (First, Middle,			C DCHOOLS
d ba	00		N.T.						,	
iges 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If item 27 is marked other than "natural", or Itams 23a or 28a-f show or other traumatic avent. The Wedical Examiner must be invitibled at	To		m Nelson			l		en Bayl		
and and is m		19a. Informant's Name/Relationship (7	*			and Number or Ru				
and salth n 27	- 3	Lisa Green -	Daughter	490	l Semina	ry Rd.,	#1211 <b>,</b> A:	lexandr	ia, V	7A 22311
s 1 an f Heal itam 3		20a. Method of Disposition		20b. Place of Dispo-	sition (Name of		Date	20c. Location -	City or To	wn, State
age onto		1 ☐ Burial 2 ☐ Cremation 3 ☐			natory or other pla		10005			
rtan rtan		'4 □Donation 5 □Other (Specify	/	Mt. Olive			9/2005		h., D	
permit. Pages 1 an Department of Heal Important: If itam 2 any injury or othar QDC8.		21. Signature of Fuheral Service Licen	+	22	. Name and Addre		Stewart 1			
0 D = ≪ 0		23a. Part1. Enter the disease, or comp	Meway	1111		nning Rd.			DC 20	0019
/Medical Examiner	Examiner	Immediate Ca. se (Final disease or confition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as b. Due to (or as c.	a consequence of):  a consequence of):	Embo	lus				Onset and Death
rres that the death certificate be exacuted signed by the attending physician and tbe detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \) 9 \( \text{Unknown} \)	d	2 Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Da	te of delive	ory Day Year
at th	<sup>5</sup> hy									
an the de	by	Part II. Other significant conditions co	entributing to death be	ut not resulting in the un	iderlying cause giv	en in Part I.	23e. Did tol	bacco use cont	ribute to th	e cause of death?
quire n sig ald b							1 □ Ye	es 2 No	3 Prob	abiy 4 Unknowi
w requir been si should	ete						24 115	1000		
The larate has	Completed						24a. Was a autops perform	med?	prior to con death?	osy findings available npletion of cause of 2 No
Phyaician: this certifica ral director, I	Be	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only on	10)		
Phyaid this co	2	1 XYes 2 No	Hospital: 1 🗌 Inpatie	nt 2 🔀 ER/Outpatient	3 DOA Oth	er: 4 🗋 Nursing Ho	ome 5 Reside	ence 6 Oth	er (Specify	()
Attanding Ph er death. ractor: After th by the funeral		27. Manner of Death  Natural 5 Pending  investigation	28a. Date of Injur (Month, Day	y 28b. Time of	28c. Injur Wor	y at	28d. Describe ho			,
0 # # c	ertiflcation:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubuilding, etc	ury - At home, farm, stre c. (Specify)			28f. Location (St City or Town	treet and Numb n, State)	er or Rurai	l Route Number,
Hospital 4 hours Funaral ely filled	Medical Ce	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	/sician: To the best of iner: On the basis of and manner sta	of my knowledge, death examination and/or inv	occurred at the tir estigation, in my c	me, date and place, opinion, death occur	and due to the ca	ause(s) and ma ate and place, a	nner as sta	ated. the cause(s)
To the within 2 To the complet	Me	29b. Signature and tile of certifie	$\mathcal{I}_{\Lambda_{\Lambda}}$		29c. Licens	e number	2	9d. Date signed	(Month, L	Day, Year)

Registrar

31. Date filed (Month, Day, Year) MAY 1 9 2005



OCME

May 13, 2005

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			For State Registrar	State of Maryla	and / Depa		Health and M	lental Hyg	iene	18527
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middla, Last)  Verdug  4a. Facility Name (If not institution, giva soligo Creek Nu	DOWIS straat and number) rsing & RE		Takoma		2. Date of Deat Month	Day Year  4c. County of Death  Montgonery	3. Time of Death
	Funeral Director		5. Social Security Number  463–38–2352  Usual Residence of Decedent	7. Age (In your 80)	rs. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, July 27,		place (State or Foreign ntry)
	ath with the Maryland 23a or 28a-f ahow wat be notified at	ector	10a. State 10b. County $D_{\bullet}C_{\bullet}$	10c.	City, Town or Lo Washing	tan				10d. Inside City Limits 1 ∰Yes 2 ☐ No
	3a or 3	I Dir	3039 Douglas St., N	1.E.		10f. Zip Code 2001	18	11	0g. Citizan of What Cou <b>U.S.</b>	ntry?
980	n 72 hours after death with the Maryland "natural", or Itams 23a or 28a-f ahow odleal Experimet must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of he f Yes, specify Cub	dispanic Origin? (Spann, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amen Black, White, Spacify:	etc.
21215-0036	- 2 10	Completed	15. Decedent's Edu (Spacify only highest gradi Elementary/Secondary (0-12)	cation a <i>complatad)</i> College (1-4or 5+)		dent's Usual Occup kind of work dona DO NOT use retiral	pation during most of works d) zider	ing	16b. Kind of Business/Ir	dustry
Maryland 2	nit. Pages 1 and 2 should be filed within ordinent of Health and Mental Hygiene. ordinit: If item 27 is marked other than injury or other traumatic event. If a M. e.	To Be Co	12 17. Father's Name (First, Middla, Last) Jim Spru	uiell			18. Mother's Name	a (First, Middla, M	,	
Mary	d 2 sho th and I th am traume		19a. Informant's Name/Relationship (Ty. Delores D. Dowo						City or Town, Stata, Zin	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 Is any injury or othar tra once.		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	20b emoval from State	. Place of Dispo cemetery, cren		ce)	Date 2	Ruther Glen,	own, State
Balti	permit. Departm Importal any inju		21. Signature of Funeral Service License		22	. Name and Addre		ette & Ass	ecc. Funeral H	ome Inc.
760,	by School of the percentage of the contribution of the control of	Ilcal Examiner	23a. Par1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):		HENRT			Approximate Interval Between Onset and Death
.O. Box 68	Physician: The law requires that the death certifica this certificate has been signed by the attending ph ral director, page 2 should be detached for use as t	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	3c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o 9 Unknown	etal death 3	Ectopic pregnancy Othar (specify)	1		23d. Date of delive Month	ery Day Year
<b>a</b>	w requires that been signed b should be deta	ed by Pł	Part II. Other significant conditions con  OI ABLITES MED						acco use contribute to tl s 2 XNo 3 ☐ Prob	
al Records,	: The law recate has be page 2 sho	Comple	DEMONTIA	CEKUBRO.	_			perform	prior to co	psy findings available mpletion of cause of 2 No
ion of Vital	nnding Physician: The lath. ath. w: After this certificate he ie funeral director, page	atlon; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1. Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 2  28a. Date of Injury (Month, Day Year)		28c. Injur Wor	y at 2		nce 6 Other (Specif	v)
Division	To the Hospital or Attending within 24 hours after death.  The the Funaral Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, stre cify)	est, factory, office	2	28f. Location (Str. City or Town,	aat and Number or Rura Stata)	l Routa Number,
	e Hospi 24 hou a Funar	Medical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	ician: To the best of my k er: On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred at the time restigation, in my o	ne, date and place, a pinion, death occurre	and due to the cared at the time, da	use(s) and manner as st te and place, and due to	ated. the cause(s)
)	Total	Me	29b. Signature and title of certifier	Pape Son			158766		d. Date signed (Month,	Qay, Year)
	Goe		30. Name and address of person who co			Print) DORIS	V. PABLO	-Bustos	20017	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 9 2005	32. Registrar's Sig	nature					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** VIOLA DANCE 2005 8:35 AM May 18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Wicomico Nursing Home Wicomico Salisbury
Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 F Director 94 214-10-9200 05-11-1911 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other traumatic event, the Medical Exemitive must be notified at 1 Yes 2 No Director VA FAIRFAX ANNANDALE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23a or 7908 INVERTON ROAD #202 22003 USA 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☐ No or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married NID DANCE Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced WHITE "naturel", 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 BOOKEEPER COUNTY ROADS BOARD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ALFRED HATTON ADA GOSLEE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANITA WRIGHT - DAUGHTER 7908 INVERTON ROAD #202, ANNANDALE, VIRGINIA 22003 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 

Cremation 3 

Removal from State \* 4 □ Donation 5 □ Other (Specify) WICOMICO MEM. PARK SALISBURY, MARYLAND 105-20-2005 21. Signature of Faneral Service Licensee 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart affure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HYPUXIA /Medical Due to (or as a consequence of). Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy į in the past 12 month Month Year Day 5 Other (specify) P.0. the ģ Part\_II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 Records, ð EMENTIA 1 ☐ Yes 2 ☐ No 4 Unknown 3 Probably Completed peeu PEIRESSION 24b. Were autopsy findings available prior to completion of eause of death? 24a. Was an has autopsy page performe certificate ANEMIA Division of Vital 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 ER/Outpatient 3□ DOA After this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural within 24 hours after death.

To the Funerel Director: Al
completely filled in by the fu M 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Fo the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D-0060515 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Mahesha Thimmarayappa M.D.</u> 614 Easternshore Dr Salisbury MD 21804 MAY"1 9 2005 State Registrar

			1 = For State Registrar	State of Ma			ent of H		l Mentai H	ygiene Reg. No.	2000	18529
	Physic	ian	Decedent's Name (First, Middle, Las	t)					2. Date of I	Death Day	/ Year	3. Time of Death
	/Medi		RHODA	MARGAR	ET D	ULEY			May	1:		M
7	Exami	ner	4a. Facility Name (If not institution, give			4b. (	City, Town, or	Location of De	ath	4c.	County of Dea	ath
			Frederick Memo  5. Social Security Number 6. Se		pital (In yrs. last birth		redei	ick If Under 24 H		1	reder	
п	Funeral Director			_M 2 <b>⊠</b> F		rs. Mon		Hours Mi		Day Year)	9. Bi	rthplace (State or Foreign country)
			Usual Residence of Decedent						Dec.	30 13	741	Virginia
	nylan how		10a. State 10b. County		10c. City, Town	or Location						10d, Inside City Limits
	e Ma	cto	Md. Frede:	rick	Mon	rovia						1 □ Yes 2 No
	72 hours after death with the Maryland naturel', or Items 23e or 28e-1 show dical Examiner must be rediffed at	Funeral Director	10e. Street and Number			10f	. Zip Code			10g. Citi	zen of What C	ountry?
	ath w	<u>ra</u>	11807 Ridgeway D	cive				21770			ited St	tates
	er de	une	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was D If Yes,	ecedent of His specify Cubar	spanic Origin? n, Mexican, Pue	(Specify Yes or I	No-	14. Race - Am Black, Whi	
36	rs aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕱N If Yes, Give Year or Dates:	0		s 2 No	Specify:			Specify:	White
9	ture I	edt	15. Decedent's Edit		16a [	Decedent's	Usual Occupa	tion				
15	n "na	plet	(Specify only highest grad	le completed)	(	Give kind o	f work done d T use retired)	uring most of w	orking	160. KII	nd of Business	sindustry
212	d within giene. or then "I	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)	Homen				0	wn Home	Э
b	e filed al Hygid other vent, I	Bec	17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Midd	le, Maiden	Sumame)	
<u>Ja</u>	should be find Mental has marked of umatic eve	To	Lee B. O'Ne	eil				Elear	or M.	Ro	bertson	n
Maryland 21215-0036	C1 10 00		19a. Informant's Name/Relationship (T)						Rural Route Num			
	permit. Pages 1 and 2 Department of Health Importent: If item 27 i eny injury of Ather tre once.		Sidney L. Duley	Husband					, Monro			1770
Baltimore,	Pages nent of h	1 8	20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ F		20b. Place of I cemetery			1	Date		cation - City or	
Ϊ	permit. Pag Department Importent: I eny injury o		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service Licens</li></ul>		Parkla		metery	-	19/05		ckville	e, Md.
Ba	permit. Departr Importe eny inju		Row in Bo	. 1					r Funer			
			23a. Part1. Enter the disease, or comp	ications that caused t	he death. Do no	P.	O. B	ox 5038	Layto	nsvil	le, Md.	20882 Approximate
	Physician	8 7	Immediate Cause (Final	ne cause on each line	١.	0 1		, odori do odran	as or respiratory	arrest,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Sepsi	S E	Coli						Days
	Examiner			Intro	i-abdi	้ ว ทาไ	100	aberi	066			Days
0		Je	Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	donsequance of	).		apse				2-23
	nd nd transi	Examiner	that initiated events	s								1
90,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a	consequence of	):						
8760,	physic the p	an/Medical		J					_			
9	eath certific attending p	/Me	IF FEMALE:	3c. If yes, outcome of	prognancy							
Вох	atten for us	lan	in the past 12 months?	3c. If yes, outcome of	Fetal death		c pregnancy			2	3d. Date of del Month	ivery Day Year
o.	at the de by the a tached	Physicia	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at ti 9□Unknown	me or death	5 Other	(specify)					- 47
S, P	de de	by Ph	Part II. Other significant conditions con	tributing to death but	not resulting in the	he underlyin	ig cause giver	in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
rds	w requires been sign should be	q pa	Thrombocyto	Penia,	coron	ary	art	ery di	Rav 10	Yes 2	No 3 □ Pr	obabiy 4 Dunknown
SCO		ompleted	/	,		(			24a. Wa	s an	24b. Were au	Itopsy findings available
Ä	9 7 9	Eo							perf	opsy ormed?	prior to death?	completion of cause of
Vital Record	sicien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place of De	1 ☐ Yes ath (Check only	2 ☑No one)	1 🗌 Yes	2 □ No
of V	ys S	To .	1 Yes 2 No	lospital: 1 Inpatient	2 ER/Outpa	atient 3	DOA Other		Home 5 ☐ Res		□Other (Spec	cify)
U		on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day )	(ear) 28b. Tim		28c. Injury a Work?	it	28d. Describe	how injury	occurred	
Si Si	Attending ir death. ector: After by the fune	catl	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			М		s 2 No				
Division	I or Attendate death Director:	Certification:	4 Homicide determined	28e. Place of Injury building, etc.	/ - At home, farm ( <i>Specify</i> )	, street, fac	tory, office		28f. Location City or To	(Street and wn, State)	Number or Ru	ral Route Number,
	Hospitel of the sale of the sa		29a, Certifier 1 Certifying Phys	icien: To the heat of	mu knowledge s	looth		d-t d -1				
	To the Hospitel or Atten Within 24 hours after deat To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Exeminate)	icien: To the best of ler: On the basis of e and manner state	xamination and/o	or investigat	ion, in my opir	, date and plac nion, death occ	e, and due to the urred at the time	date and p	ind m <i>a</i> nner as place, and due	stated. to the cause(s)
	To the Ithin 2 To the complet	Me	29b. Signature and title of certifier	_			29c. License	number		29d. Date	signed (Month	n. Day, Year)
•	8		> When				D62	3180			May 16	, 2005
			30. Name and address of person who co	mpleted cause of dea	th (Item 23a) (Ty	rpe, Print)						
				MO TO	0 Wes	st 7+	h St	rect,	tredo	rick	Y -	
	Sta Registra		31. Date filed (Month, Day, Year) MAY 1 8 200	32 Registrar's	s Signature	berte		,	Frede			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Mary Elizabeth DeLauney May 18,2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood At Williamsport Williamsport Washington 8. Date of Birth
(Month, Day, Year)
Anril 30,1917 Maryland 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday). Birthplace (State or Foreign Country) **Funeral** 1 M 21 F Days Yrs. Director 217-18-8947 88 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits other traumatic evant, the Medical Examiner short be notified at 1 Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23a 1110 Potomac Ave. 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No ð 3 Widowed 4 □ Divorced 'natural'. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) 12 shoutd be filed w h and Mental Hygier 7 is markad other th Unknown Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be Iment of Health and Menta lant: If item 27 is markad Edward Ε. Raker Sarah Salley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DeLauney Ronald R. 10714 Downsville Pike Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department o Important: If \* 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery May 21,2005Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hagerstown, MD Rest Haven Funeral Chapel 1601 Pennsylvania Ave. 23a. Part1. Enter the disease, or complications that reused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. opproximate Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last burial-t Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ō in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. the detached ģ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed of Vital 2 No 2 🗆 No 6130 1 ☐ Yes or Attending Physician: Be referred to medica 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No Other: ٢ 3□ DOA 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1 Natural 2 Accident Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Year Billie Valeria D'Alessio 10:42 PM /Medical May 16 2005 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 88 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Dec. 1, Year) 1916 9. Birthplace (State or Foreign **Funeral** Days 1 M 200 Hours 148-09-5823 Director Usual Residence of Decedent the Maryland 10a. State 10h County 10c. City, Town or Location s 23a or 28a-f show 10d. Inside City Limits MD Director Frederick Middle town 1 X Yes 2 ☐ No 10e. Street and Number
2 Eastern Circle 10f. Zip Code 10g. Citizen of What Country? death with 21769 USA Funeral , or items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ified within 72 hours after of Hygiene.

Hygiene.

other then "netural", or itel Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 þ 1 ☐ Yes 2 XX No Specify: other traumatic event, the Medical Example 3 Widowed 4 □ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Importent: If item 27 is marked othe eny injury or other treumetic event, since. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Hryn Pauline Podgurski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James D'Alessio (Son) 2 Eastern Circle, Middletown, MD 21769 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory5/21/05 Smithsburg, MD 21. Signal re of Funeral Service Lic Bonald de B. Thompson Funeral Home D 31 E. Main St., Middletown, MD 21769 he disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, it failure. List only one car's on each line. 93a. Part1. Enter Approximate Interval Between Onset and Death Immediate Cause (Final Physician ON GESTIVE MEARIT PALLUPE disease or condition resulting in death) Mars /Medical **Examiner** METERIOSCUPROTIC CHROIGNASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) physician and the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as the attending use IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 pronths? for Day Year Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by I significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 4 Unknown 1 Yes 2 No 3 Probably Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy rmed? No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) tion: 27. Manner of Death 28b. Time of 28c. Injury at Work? / iter 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending after death investigation 1 ☐ Yes 2 ☐ No 2 Accident Certificat the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and manner stated. (Check only onel the To 29b. Signature and the of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2003 30. Name and address of person who comp d cause of death (Item 23a) (Type, Print) PUNSLICE LGALTER 31. Date filed (Month) 32. R strar's Signature 2005 Registrar

			1 - For State Registrar	State	of Maryla		artment of H rtificate of L	ealth and Me		CUUS	18532
			Negistrar     Necedent's Name (First, Middle	a (ast)			Timeate of L		Reg. No. 1 2. Date of Death	Vo.	3. Time of Death
	Physici	an							Month D	ay Year	A
	/Medic		Rosalie Adell E							23 2005	10.13
	Examin	ier	4a. Facility Name (If not institution				4b. City, Town, or	Location of Death	4	tc. County of Death	1
			Washington Coun			6 4114 1	Hagerst	The second secon		shington	
:	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🌠 F		. last birthday) Yrs.	If Under 1 Year Months Days	Hours   Min.	<ol> <li>Date of Birth (Month, Day, Yea</li> </ol>	9. Birth	place (State or Foreign intry)
	Director		219-12-1705 Usual Residence of Decedent	71	81	115.			Dec. 31 1	923 Penns	sylvania
	and and		10a. State 10b. County		10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Aary Ped	ō								i	1 Yes 2 □ No
	28a-	Director	Maryland Washi	ngton		Hag	erstown				
	with a or		Toe. Street and Number				10f. Zip Code		10g. (	Citizen of What Cou	intry?
	e 23	Funeral	11 W. Baltimore				217			S.A.	
	er de	Š	11. Marital Status	Armed Fo		J.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spec n, Mexican, Puerto R	cify Yes or No- lican, etc.)	14. Race - Amer Black, White	
36	s aft	by F	1 Never Married 2 Marr	If Yes, Gi	ve		1 ☐ Yes 2 <b>X</b> No	Specify:		Specify:	
21215-0036	72 hours after death with the Maryland natural, or Iteme 23a or 28a-f show lical Examiner must be notilled at	b b	3 ☐ Widowed 4 🎇 Divorced	Year or D	ates:					W	nite
7	"nat	Completed	15. Decedent (Specify only highes			(Give	dent's Usual Occupa kind of work done di	uring most of working	g 16b.	Kind of Business/li	ndustry
2	within ene. than "	E G	Elementary/Secondary (0-12)	College (	1-4or 5+)		DO NOT use retired)				
2	be filed within 72 hours after death with the Marylan Hygiene. I Hygiene. I dother than "natural", or Iteme 23a or 28a-1 show event, the Maryleal Examinating must be notified at		8 17. Father's Name (First, Middle,	0		Sa	les Clerk			Retail	
Ĕ	be f ad of	Be		Last/				18. Mother's Name	(First, Middle, Maide	en Sumame)	
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ō	t of h		1 ☐ Burial 2 🏋 Cremation	3 Removal from		cemetery, crer	sition (Name of matory or other place	Da Da	16 20c.	Location - City or T	own, State
Ë	Pa tmen tant: jury		` 4 □Donation 5 □ Other (Si		Has	gerstow	n Cremato	ry   5/24/	05 Hag	erstown,	Maryland
Baltimore,	permit. Pages Department of H Important: If ite eny Injury or of once.		21. Signature of Funeral Service	_icensee		22	. Name and Address	s of Facility Min	nich Fune	ral Home	
_	ā O E e d		Robertis	Carlie				on Blvd.		n, Md. 2	1740
П			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that o	aused the dea ach line.	th. Do not ent	er the mode of dying	, such as cardiac or	respiratory arrest,		Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition		Reno	al F	a, lura				Onset and Death
	/Medical		resulting in death)	Due to	or as a conse			-			
	Examiner		Sequentially list conditions,	, t	Scudo	w cw,	ora mous	Coli	ris		
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	cuter nd rans	Examiner	Cause (Disease or injury that initiated events	c.	9412	679	Track	· Coli	1100		
oʻ	e exe	Ä	resulting in death) Last	Due to	(or as a conse	quenc = of);					
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	ng pl		IF FEMALE:	Ì							
Вох	attending for use es	2	23b. Was decedent pregnant	23c. If yes, out	come of pregn		Ectopic pregnancy			23d. Date of deliv	ery
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'n.	res that the death cerigned by the attendin	by P	Part II. Other significant condition	ns contributing to de	eath but not res	sulting in the ur	nderlying cause giver	n in Part I.	23e. Did tobacco	use contribute to t	he cause of death?
ğ	w require been sig should b								1 ☐ Yes 2	2 □ No 3 □ Prot	Dably 4 Unknown
000	aw re	oiet							24a. Was an	24b. Were auto	opsy findings available
Vital Records,	The law requires that the death certiste has been signed by the attending bage 2 should be detached for use e	Completed					<u> </u>		autopsy performed?	prior to co death?	mpletion of cause of
		0	25. Was case referred to medical					20 Bloom of Brook (	1 Yes 2 N	o 1 ☐ Yes	2 □ No
5	ysicii is cer direct	0	examiner? 1 ☐ Yes 2 € No	Hospital:	npatient 2	ER/Outpatien	Othor	26. Place of Death (		2 T 2 1 12 1	
o a	g Phy eration	-	27. Manner of Death	28a. Date o	of Injury	28b. Time of	28c. Injury		5 Residence d. Describe how inju		y)
0	th.	텵	1 Anatural 5 ☐ Pending 2 ☐ Accident investig	,	th, Day Year)	injury	Work?	? es 2 □ No			
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á.	afte Dire	ert	4 Homicide	buildi	ng, etc. (Speci	fy)			City or Town, Star	te)	
		2	29a. Certifier 1 Certifying	Physician: To the	best of my kno	owledge, death	occurred at the time	e, date and place, an	d due to the cause/	s) and manner as s	tated.
	hours ners	60	(Check only 2 Medical E	xaminer: On the ha	asis of examina	ation and/or inv	estigation, in my opi	nion, death occurred	at the time, date an	nd place, and due to	the cause(e)
	ne Hospit n 24 hours ne Funera	edice	one)	and mann	ier stated.						o ine cause(s)
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29b. Signature and title of certifier	and mann	ner stated.		29c. License		29d. Da	ate signed (Month,	
: :	To the Hospital or Atlanding Pry within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral or	Medica	5.107	and mann	ner stated.			number 60396		ate signed (Month,	Dey, Year)
	l o the Hospit within 24 hours To the Funers completely fille	Medica	29b. Signature and title of certifier	Muhen	ier stateg.	ກ 23a) (Tvpe 1	000	60396	05	124105	Dey, Year)
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Physicia		1. Decedent's Name (First, Mid		-				2. Date of D		ay Yea	3. Time of Death
/Medica	al .	Eddie Charles			+"			May 1	2, 2	005	11:57 p. <sup>M</sup>
Examine		4a. Facility Name (If not instituti		,			or Location of De	ath	1	c. County of De	
		Malcolm Grow H  5. Social Security Number	+ +	ge (In yrs. Ia	ast birthday)	Camp Sp		rs. 8 Date of B			eorge's
uneral Director		233-84-0476	1 X M 2 □ F	54	Yrs.	Months Days	Hours Mi		25.1	950 We	Birthplace (State or Foreign Country) EST Virginia
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Show	7	10a. State 10b. Coun	,		, Town or Lo						10d. Inside City Limits
28a-f	Director	Md. Princ	e Georges	For	estvi				10.0		1 ☐ Yes ¾XXNo
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tica	To	James Faulkr	er				Lou	ise Pann	ell		
is markad or		19a. Informant's Name/Relation			19b. Mailir	ng Address (Street	and Number or F	Rural Route Num	ber, City	or Town, State	, Zip Code)
othar tra	-	Shirley Strong	;-Faulkner(Wi			Hil Mar			· —		
or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from State	cer	metery, crea	osition (Name of matory or other pla	ce)	Date	20c. L	Location - City of	or Town, State
any injury		`4 □Donation 5 □Other (		Linc		Cemetery		19-05	Su	itland,	Md.
Important: If i any injury or o		21. Signature of Funeral Service	Rell			2. Name and Addre	Ве	ell F <u>u</u> ne	ral	HomePA	
	-	23a. Part1. Enter the disease, of heart failure.	or complications that caused	d the death		6503 01d				Hills,M	
39)		shock, or heart failure. Lis Immediate Cause (Final	st only one cau on each li	ne Narc	cotic	and alcol	nol into	xication	1	12	Approximate Interval Between Onset and Death
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State of Maryland / Department of Health and Mental Hygiene 15 18534 For State Registral Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Isabelle Elizabeth Goens 2005 11:25 Å May 16, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Southern Maryland Hospital " Clinton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months 1 ☐ M 2 3 F 89 Director 236-56-3131 Sept. 27,1915 Virginia Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-1 show r than "natural", or itams 23a or 28a-f shov If e Modical Expenies and be notified at Washington 1 Yes 2 □ No Director TY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20019 3760 Minnesota Ave, NE #405 permit. Pages 1 and 2 should be filed within 72 hours after death v Capatiment of Health and Mental Hygiene. In profrant: If item 27 is marked other than "natural, or itams 23a any injury or other traumatic avant. It is Medical Facilities 200.00. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Black Specify: Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+) Private Family Domestic 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nora Parker Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 4910 Stan Haven Ct, Temple Hills, MD 20748 19a. Informant's Name/Relationship (Type, Print) Martha Brooks/Guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 5/21/05 Harpers Ferry, W. VA Cedar Hill Cemetery \* 4 □ Donation 5 □ Other (Specify) 21. Signalus of Funeral Spir 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd, Camp Springs, MD 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause process line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Jua to (or as a consequence Examiner The law requires that the death certificate be executed nding physician and use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atten for u Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 1 Yes 2 No 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Records, 2 1 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 HO 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 🗆 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural Injury 5 Pending 1 🗌 Yes death. 2 Accident investigation Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funaral D 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Laxmi Berwa 7700 Old Branch Ave, Suite 101, Clinton, MD 20735 31. Date filed (Month, Day, Year) State Registrar MAY 1 9 2005

				State of Manuana								
			1 - State	State of Maryland		rtificate of				2005	18595	
			Registrar  1. Decedent's Name (First, Middle,	Last)		tineate or i	Dealii	2. Date of Dea	Reg. No.		3. Time of Death	
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	/Medic Examin		LILLIAN ELIZABETH GOTZMER  4a. Facility Name (If not institution, give street and number)			4b. City, Town, o	r Location of Deat			County of Deat		
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	Funeral			S. Sex 7. Age (In yrs. las	t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Oate of Birt	h		hplace (State or Foreign	
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7	2		Usual Residence of Decedent	140.00								
-	ehow det	_	10a. State 10b. County	10c. City, 1		cation					10d. Inside City Limits	
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1			106. Street and Number 10f. Zip Code 10g. Citizen of What Country?						ountry?			
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1		ņ	11. Marital Status  1 Never Married 2 Marrie	12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican,		to Rican, etc.)	n, etc.) Black		, White, etc.	
36		ted by	3√2 Widowed 4 □ Divorced	If Yes, Give△	Year or Dates:  cation 16a, Deced		1 ☐ Yes 2 ☐ No Specify:  dent's Usual Occupation			Specify: White . Kind of Business/Industry		
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			17. Father's Name (First, Middle, La	•				Name (First, Middle, Maiden Surr				
/ai			William Koerber		Elizabeth Schneid				lder	ler Koerber		
Maryland	and l		19a. Informant's Name/Relationship	p (Type, Print)	19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Numbe	r, City or	r Town, State, 2	Zip Code)	
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ω.	Department of Health Important: If item 27 any injury or other tr. once.		Carl Cotzmer (S 20a. Method of Disposition 1 Buylal 2 Cremation 3	20b. Plac	ce of Dispo netery, crer	sition (Name of matory or other place	ce)	Date	20c. Los	cation - City or	Town, State	
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State of Maryland / Department of Health and Mental Hygiene 1- State 8, per fh,gc,5/25/05 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 645hm Haynali MAY 2005 16 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ▼ M 2 □ F Yrs. 191-09-5367 87 |Pennsÿlvania **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If itam 27 is marked other than "natural", or itams 23e or 28e-f show 10c. City. Town or Location 10a. State 10h County 10d. Inside City Limits r than "natural", or itams 23e or 28e-f show The Madical Examinating by motified at 1 X Yes 2 ☐ No Directo Md. Anne Arundel Crofton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1719 Peartree Lane 21114 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WW∏ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Route salesman Food 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nicholas Haynali Eva Copcho 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bertha E. Haynali - Wife 1719 Peartree Lane, Crofton, Maryland 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: If its any injury or of once. 1. ■ Burial 2 Cremation 3 Removal from State Md. Veterans Cemetery 05-20-05 \* 4 □ Donation 5 □ Other (Specify) Crownsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 N.W. CRain Hwy., Bowie, Maryland 20715 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ischemic cardlogopath 2415 **Physician** disease or condition resulting in death) /Medical Examiner 15415 diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and I for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed ar dementa 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has bibleral leg amputations (peripleral vasculardismo) yes 200000 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 FER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No ပ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 TSuicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours a tha Funaral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0 D44290 he 10755 Falls Road Sule 200 30. Name and address of person who Krohe moth 31. Date filed (Month, Day, Year) State MAY 1 9 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar Amend#4a.Per ME PCC 5-19-05 cr Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 12.49 2005 Leny Henry Howard /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Circle Land over Prince 6 Allendale corpes If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Y)
Jan. 30, 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1X M 2□ F Director 1934 Wash., 578-46-2684 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10d. Inside City Limits 10c. City, Town or Location 7 is marked other then "naturel", or Itams 23a or 28e-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Directo Maryland Prince George's Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20785 7607 Allendale Circle United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify Specify: Black ģ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Crew Chief Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stella Howard Joseph Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health ar Important: If item 27 Is eny injury or other trau 6107 Breezewood Ct., #102 Greenbelt, MD Carolyn Morgan - Sister 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State
1 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Cem. 5/12/2005 Suitland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home Drewark one 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Chise (Final Ity sertensive Heart **Physician** Arterioscherotic disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier ical within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300/ Hespital 31. Date filed (Month, Day, Year) . Registrar's Signature... State 9 2005 Registrar

			1 - For State Registrar	State of Mary		partment of H Prtificate of L		lental H	lygie: Reg.		
	Physici		Decedent's Name (First, Middle, Last     MARIE H.	HOUSLEY				2. Date of Month	Death	Day Year	3. Time of Death (
	/Medic Examir		4a. Facility Name (If not institution, give Salisbury Nursing	street and number)	Center	4b. City, Tawn, ar	Location of Death	er:		4c. County of Dea	ath
	Funeral Director		5. Social Security Number 6. S 244-14-3351		yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of (Month, 10–30	Birth Day, Ye	9. Bi	rthplace (State or Foreign owntry) oth Carolina
	Maryland a-f show lifed at	tor	Usual Residence of Decedent  10a. State 10b. County  Delaware Sussex		c. City, Town or Laurel	Location	,	-			10d. Inside City Limits 1 □ Yes 2 ☒ No
	th with the 23a or 28s	Funeral Director	10e. Streel and Number 11228 Laurel Rd			10f. Zip Code 19956			10g.	Citizen of Whal C	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatile and Mental Hygiene.  Department of Heatile and Mental Hygiene.  Department of Heatile and Mental Hygiene.  Any njury or other traumatic event, the Medical Evaninar must be notified at any njury or other traumatic event, the Medical Evaninar must be notified at any njury or other traumatic event.		11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	in U.S. 13	N Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or Rican, etc.)	No-	14. Race - Am Black, Whi	ite, elc
SLEY Maryland 21215-0036	within 72 ho ene. than "natur	Completed by	15. Decedenl's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Gir	tedent's Usual Occupa ve kind of work done of DO NOT use retired Ome Maker	ation during most of worki )	n <i>g</i>		Kind of Business	
r Jand 2	uld be filed Mental Hygi irked other	To Be Co	17. Father's Name (First, Middle, Last)  Joseph Hennesse	<u>-</u>			18. Mother's Name Stella (				
	and 2 should ealth and Men n 27 is marke		19a. Informant's Name/Relationship (Marjorie Hartbaue	r - sister	1122	iling Address <i>(Street a</i> 8 Laurel R	Rd, Laurel	L, DE	1995	56	
	t. Pages 1 rment of H rtent: If iter		20a. Method of Disposition  1 □ Burial 2 ◯ Cremation 3 □  '4 □ Donation 5 □ Other (Specify	Removal from State	cemetery, cr capitol	position (Name of ematory or other place Crematory	05/18	3/2 <b>0</b> 05		. Location - City of Dover, DE	
MARIE Raltin	Departi Departi Imports any office.		21. Signalur of Funefal Service Lice  John A. Crans  23a. Fart. Enter the disease, or components only a shock, or heart failure. List only	round to		22. Name and Addres Cranston P O Box	ı Funeral	Home	DE-1	9973	Approximate
•	r nysician /Medical Examiner	)r	disease or condition resulting in death)	a. Due to or as a col	nsequence of	E.	eos	- Ca	20	4	Interval Between Onset and Death
8760	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, it also, leading to minibulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a col							
P.O. Box 6	the death certifi	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, autcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			-	23d. Date of de Month	livery Day Year
	w requires that been signed t		Part II. Other significant conditions c	ontributing to death but no	t resulting in the	underlying cause give	en in Part I.				o the cause of death?
I Reco	The law rate has be page 2 sh	Completed				·		24a. Whau pe	topsy rtomed	? prior lo death?	ulopsy findings available completion of cause of
of Vita	iding Physician: The the this certificate funeral director, page	To Be	25. Was case referred to medical examiner? 1 Tyes 2 Type 27. Manner of Death	Hospital: 1 Inpatient 28a. Dale of Injury	28b. Time	of 28c. Injury		me 5□Re	sidence	6 □Other (Spe	ocify)
Division of Vital Becords	To the Hospital or Attending within 24 hours after death of To the Funeral Director: After completely filled in by the fune	Certification:	1 Adtural 5 Pending 2 Accident 3 Suicide 6 Could not be determined			M 1 D	(? Yes 2□No	28f. Location City or 7			ural Route Number,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my niner: On the basis of exa and manner stated.	knowledge, demination and/or	ath occurred at the tim investigation, in my op	ne, date and place, a pinion, death occurr	and due to the	ne cause e, date a	e(s) and manner a and place, and due	s stated. e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier.  30. Name and address of person who	Acompleted cause of death	(Item 23a) (Type		number	9	29d. I	Date signed (Mont	th, Day, Year)
1	Sta	ite	WILLIAM ROBINS, 31. Date filed (Month, Day, Year)				RY, MD. 2]	.804			
	Registr	20 0	MAY 1 8 2	32. Poistrar's S	15	goods)					

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

				partment of Health and Mental Hygiene ertificate of Death	3.0
	Physic /Medi		1. Decedent's Name <i>(First, Middle, Last)</i> Ruth Elisabeth Haddon	2. Date of Death Month Day Year Nay 20 2005 18:28	ath M
	Examii Funeral	ner	4a. Facility Name (If not institution, give street and number)  Washington County Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	4b. City, Town, or Location of Death Hagerstown    If Under 1 Year	oreian
	Director		223-01-8868 1	September 21,1913 Virginia	
	n the Maryland r 28e-f show profilled at	Director	Maryland Washington Hagers  10e. Street and Number	stown 1 Tyes 2	
	after death with or Items 23e or ruiner must be r	Funeral Dir	1125 Professional Court	10f. Zip Code 10g. Citizen of What Country? U.S.A.	
900	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-1 show is Medical Evantrer must be notified at	þ	1 Never Married 2 Married 1 Yes 2 No	. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1☐ Yes 2☑ No Specify:  14. Race - American Indian, Black, White, etc.  Specify: White	
Maryland 21215-0036	within 72 ha	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)  memaker  0 wn Home	
land 2	2 should be filed within and Mental Hygiene. is marked other then raumatic event, ILEM	To Be Co	17. Father's Name (First, Middle, Last)  Edward Tilden Waltha	18. Mother's Name (First, Middle, Maiden Surname)	s
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Andrea H. Kautz Daughter 822	ling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Dewey Avenue, Hagerstown, Maryland 21742	
Baltimore,	Page ment o ant: If ury or		1  Burial 2  □ Cremation 3  □ Removal from State  1  □ Donation 5  □ Other (Specify)	w Cemetery 05-28-05 Richmond, Virginia	
Ba	permit Depart Import any Inj		N. 1226 Benuty 40	2. Name and Address of Facility Indrew K. Coffman Funeral Home, Inc. D East Antietam Street, Hagerstown, Md. 21740 Approximate Approximate	)
	Physician /Medical Examiner	<u>.</u>	23a. Part1. Enter the disease, or complications that caused the death. Do not enshook, or heart failure. List only one gause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to a ras a consequence of):  Sequentially list conditions,  b.	Inferval Between Onset and Deat	n th
8760,	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of the part of t		
Box 6	death certif e attending od for use as	Completed by Physician/Med		□Ectopic pregnancy 23d. Date of delivery □ Other (specify) Month Day Year	
Records, P	requires that the peen signed by th hould be detache	ted by P	Part II. Other significant conditions contributing to death but not resulting in the under the significant pulmonary embols	underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death	
l Rec	n: The law r icate has be r, page 2 sh		plus ger intestinal perforation	24a. Was an autopsy performed?  1 Yes 2 No 1 Yes 2 No	iable of
Zi.	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: Inpatient 2 ER/Outpatien	26. Place of Death (Check only one)  ont 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	
	To the Hospitel or Attending Physician: The law within 24 burus after death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2:	atlon; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury		
5	itel or Atters after de ral Directo	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	City or Town, State)	
	e Hospitel 24 hours a e Funeral letely filled	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death (Check only one)  1 Medical Examiner: On the basis of examination and/or invand manner stated.	h occurred at the time, date and place, and due to the cause(s) and manner as stated. In the cause (s) are the cause (s) in the cause (s)	
2	To the within 2 To the complete	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Dey, Year)	
100	_		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) 1 5 25 18   5/21/05	
4-3	Sta Registr		31. Date filed (Month, Day, Year)  NAY 2 3 2005  A 2 3 2005	rive recogsulle juaryland 21/56	

			Please  1 - Stata Registrar	State of Ma	ryland / De	partment of leartificate of	Health and I	Mental Hyg		2005	1854
	ysicia Medic		Decedent's Name (First, Middle, Las     Jayvon Juel Hunt					2. Date of Dea Month	th Day	2005	3. Time of Death
	camin		4a. Facility Name (If not institution, give Washington Count		1	4b. City, Town, Hagers	or Location of Death			county of Death hington	
	neral ector		N/A	7. Age	(In yrs. last birthda Yrs.	y) If Under 1 Year Months Days		8. Date of Birth (Month, Day May 16,	Year) 200	9. Birthp Count Mary	lace (State or Foreign stry) 1and
Maryland f show	led at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Washingt	ion	10c. City, Town or Hagersto					1	0d. Inside City Limits 1   Yes 2  No
3a or 28a	If be not	Direc	10e. Street and Number 732 W. Washingtor			10f. Zip Code 21740			10g. Citize	en of What Cour	-
paritimories, Mai yitaling 212150000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mentall Hygiene. Importent: If lien 27 is marked other than "naturel", or items 23a or 28a-f show	anniner mu	by Funeral	11. Marital Status  1 💆 Never Married 2 🗆 Married 3 🗆 Widowed 4 🗀 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:	Ever in U.S. 1	3. Was Decedent of If Yes, specify Cub		pecify Yes or No- o Rican, etc.)		4. Race - Americ Black, White,	an Indian,
hin 72 hou	Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0·12)	ucation de <i>completed)</i> College (1-4or 5	(Gi	cedent's Usual Occu ve kind of work done . DO NOT use retire	during most of wor	king	16b. Kind	d of Business/Ind	dustry
Dallimore, Maryland AIA 15-0030 permit. Pages 1 and 2 should be tiled within 72 hours af Department of Health and Marial Hygiens, 19 moorpent: if liem 27 is marked other than "naturel; or	evsnt, the	Be	17. Father's Name (First, Middle, Last)  Juel D. Hunt		*/	N/A		ne (First, Middle,	Maiden S	N/A Sumame)	
Mich y ic	treumatic	၉	19a. Informant's Name/Relationship (7 Misty D. Burton/Me			uling Address (Stree	t and Number or Ru		r, City or		Code) MD 21740
norc, ages 1 an ant of Heal	y or other		20a. Method of Disposition  1 \( \) Burial 2 \( \) Cremation 3 \( \)  4 \( \) Donation 5 \( \) Other (Specify	Removal from State	20b. Place of Dis	position (Name of rematory or other place) ven Cemete	ice)	Date	20c. Loc	ation - City or To	own, State
permit. P Departme	any injur once.		21. Signature of Funeral Service Licen			22. Name and Addr	ess of Facility Re	st Haven	Fun	eral Cha	apel
Physi /Med	dical		23a. Part 1. Enter the disease, or composition of the composition of the composition of the condition resulting in death)	a Prema	the death. Do not ele.  ### April 1  a consequence of):	enter the mode of dy	ing, such as cardiad	or respiratory an	rest,		Approximate Interval Between Onset and Death
ate be executed EXE	burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):						
The law requires that the death certificat are has been signed by the attending phy	should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pregnand 5 □ Other (specify)	су		23	3d. Date of delive	ery Day Year
quires that	uld be deta	ed by Ph	Part II. Other significant conditions of		9	a underlying cause g	ven in Part I.				he cause of death? pably 4
The lav	9 5	Complet						24a. Was autop perfor	med?/	24b. Were auto prior to co death? 1 \( \text{Yes}	psy findings available mpletion of cause of
VICION: The	director.	Be	25. Was case referred to medical examiner?					ath (Check only o	ne)		
Physicien:		L O	1 Yes 2 No		nt 2 ER/Outpa	Ment 3 DOA		lome 5 Resid			y)
To the Hospitel or Attending Phys within 24 hours after death. To the Euperel Director: After this	by the funer	Certification:	27. Manner of Death  1 Actural 5 Pending investigation  3 Suicide 6 Could not be determined		Year) Injur	y W	ork? ]Yes 2 □No	28d. Describe h	Street and		al Route Number,
Hospitel or 4 hours after	ely filled in	edical Cert	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exan	ysician: To the best of the basis of	of my knowledge, de examination and/or	eath occurred at the	time, date and place opinion, death occu	e, and due to the o	cause(s) a	and manner as s	tated.
To the l	сотріві	Med	29b. Signature and the of codifier	and manner sta	ited.						
SH-0			30. Name and address of person who	completed cause of d	eath (Item 23a) (Type fferson	pe, Print) Bluck Su	nith shu	-5 Mai	ylan	0	
В	Sta		31. Date filed (Month, Day, Year)	2005 32. Registra	ar's Signature	South					

		•	1- State of Maryland / Dep	partment of Health and N ertificate of Death		ene 2005	18541
æ	Physicia	an	1. Decedent's Name (First, Middle, Last)  Leon C. Jordan, Jr.		2. Date of Death Month May	Day 2005	3. Time of Death 5:30 PM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	-	4c. County of Death	J:30 I
			Holy Cross Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Silver Sprin		Montgom	
	Funeral Director		578–66–1141 1 2 55 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y July 8,	1949 Was	place (State or Foreign h., DC
	fand W		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	Location			10d. Inside City Limits
	e Mary Sa-f sh Liffed	ctor	DC	Washingt	on		1 XYes 2 No
	with th	Dire	10e. Street and Number 1713 Erie St., S.E.	10f. Zip Code 20020	100	g. Citizen of What Cou United	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, Ite Medical Exemiter must be notified at once.	y Funeral Director	11. Marital Status  1 Was Decedent Ever in U.S. 13 Amed Forces?  1 Was Decedent Ever in U.S. 13 Amed Forces?  1 Was Decedent Ever in U.S. 13 Amed Forces?  1 Was Decedent Ever in U.S. 13 Amed Forces?	B. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	can Indian, etc.
9	2 hours atural',	ted by		edent's Usual Occupation	. 16	6b. Kind of Business/Ir	lack dustry
21215-0036	within 73 ane. than "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of work DO NOT use retired) Security Specialis		Governm	ent
	other (	Be Co	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		ent
Maryland	ould by	To E	Leon C. Jordan, Sr.		Edna		
Mai	nd 2 st alth and 27 Is n r traun			iling Address (Street and Number or Rul 1713 Erie St., S.E			o Code)
Baltimore,	Pages 1 annent of Heaturt: If item		20a. Method of Disposition  20b. Place of Discometery, comparing 3 Democratic State  20b. Place of Discometery, comparing 3 Democratic State Sta		Date 20	Landover,	·
Balt	permit. Departr Imports any inju		21. Signature of Puneral Service Licensee	22. Name and Address of Facility St. 4001 Benning Rd.		eral Home	019
	Pnysician /Medical		23a. Part   Enter the disease, or complications that caused the death. Do not e shoot, or heart failure. List only one cause on each line.  Immediate Oause (Final disease or condition resulting in death)  Due to (or as a consequence of):				Approximate Interval Between Onset and Death
38760,	cate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c				
.O. Box 68	death certifie attending	Physiclan/Med		B □Ectopic pregnancy i □ Other (specify)		23d. Date of deliv Month	ery Day Year
ecords, P.	law requires that the as been signed by th 2 should be detach	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to to	
$\mathbf{x}$	The ete ha page	Completed			24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
Vital	Physician: The this certificete ral director, pag	o Be	25. Was case referred to medical examiner?  1  Yes 2 XNo Hospital: 1 Inpatient 2 ER/Outpati		th (Check only one)		
of	ding h. After fune	-	27. Manner of Death 1 XNatural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at	28d. Describe how	ce 6 □Other (Speci v injury occurred	ry)
Division	or Attending after death. Director: Afte d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in the Funeral Direction of the Funer	edical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cau red at the time, date	use(s) and manner as s e and place, and due t	stated. o the cause(s)
	To the To the comp	×	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month,	, ,
R	(5)	l k	30. Name and address of person who completed cause of death (Item 23a) (Typ		nuina M	May 9,	2005
	Sta	ate.	31 Date filed (Month Day Year) 42 Registrar's Signature	o Circle, Silver S	pring, MD	20906	
	Regist		MAY 1 9 2005 Bearing & pre	the same of the sa		-	

Wonho Kim 05-03402 RPD

5-03402 PD		For	State of Mary	land / Dep	artment of He	ealth and M		_	ibie.	
		1 - State Registrar  1. Decedent's Name (First, Middle)	die, Last)	Ce	rtificate of E	Death	2. Date of Death	-	105	3. Time of Death
/M	sician edical miner	Won Ho Kim 4a. Facility Name (If not institution Anne Arundel	on, give street and number) General Hospit	al	4b. City, Town, or 1		May 16,	4c. Count	y of Death	1222 P M
Fune Direc		5. Social Security Number  None  Usual Residence of Decedent	11XM 2□ E	yrs. last birthday, 23 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 9,	Year) 1981	9. Birthp Cour S	place (State or Foreign ntry) .Korea
21215-0036 ed within 72 hours after death with the Maryland gjene. er than "natural", or itams 23a or 28a-f show	leted	10a. State 10b. Count  Md. HOW.  10e. Street and Number  10448 Stansfie  11. Marital Status  1 Never Married 2 Ma  3 Widowed 4 Divorce  15. Decede (Specify only high)  Elementary/Secondary (0-12)	21d Rd.  12. Was Decedent Ever Armed Forces?  1	16a. Dece (Give life.	10f. Zip Code 20723  Was Decedent of His If Yes, specify Cuban 1 □ Yes ▼▼ No Ident's Usual Occupat a kind of work done do DO NOT use retired)	Specify: tion uring most of work	ecify Yes or No-Rican, etc.)	Speci 6b. Kind of E	What Cour ea ce - Americ ck, White, fy: Asia	can Indian, etc. an
be file oth	B B	12 17. Father's Name (First, Middle Jong Lok Kim 19a. Informant's Name/Relation			dent		e (First, Middle, M Lyo Park		me)	o Cada
ore, ges 1 an t of Heal		Won Kyoung Par  20a. Method of Disposition  1 □ Burial 2 ☑ Cremation  4 □ Donation 5 □ Other (  21. Signature of Furreral Service)	ck (Sister)  3 □Removal from State   Specify)	1044 20b. Place of Disp cametery, cre Metropol	8 Stansfie contion (Name of matory or other place itan Crema 2. Name and Address	eld Rd.,L	aurel,Md Date 2 -05 A	.20723 Oc. Location 1exand	Google City or To Iria, V	own, State  Ja.  Service
Physical Medic Examine Examine sign and Medic	icai Examiner	23a. Part1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, I are later cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	death. Do not en	2303 Kayak ter the mode of dying				1.2077	Approximate Interval Between Onset and Death
Box auth cert	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	_		1	ate of delive	ery Day Year
Records, Pelaw requires that has been signed to	pleted by	Part II. Other significant condit	ions contributing to death but no	ot resulting in the t	inderlying cause giver	n in Part I.	23e. Did toba  1  Yes  24a. Was an autopsy	2 L <b>X</b> No	3 Prob	ne cause of death?  ably 4 Unknown  psy findings available  mpletion of cause of
Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funerial Director: After this certificate ha	o Be	3 Suicide 6 Coulc 4 Homicide deten	Hospital: 1 Inpatient  28a. Date of Injury (Month, Day Ye tigation I not be mined  28e. Place of Injury building, etc. (S	At home, farm, st	nt 3 DOA Cther of 28c. Injury Work M 177 reet, factory, office	at ? es 2 No	1 X ves 2  n (Check only one me 5 ☐ Resider 28d. Describe how 5 ☐ Check only one 28d. Location (Str. 7 200 7 200 5 € C	No N	her (Specify rred Elec-	I Route Number,
To the Host within 24 ho	Medical	29a. Certifier 1 Certify (Check only one) 2 Medica	ing Physician: To the best of m Il Examiner: On the basis of exe and manner stated.	y knowledge, dea amination and/or ir	29c. License	number	ed at the time, da	d. Date signe	and due to	Day, Year)
Rec	State gistrar	31. Date filed (Month, Day, Year	n who completed cause of death	sk mf	111 Penr	n Street		lay 17		
DHMH 17 Re	v 1/2001		, , , ,	-						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 0600 M 15 2005 THADDEUS KUCHARSKI 05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WICOMICO SALISBURY 440 PENNSYLVANIA AVENUE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 07-27-1927 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1√2 M 2□ F 77 341-20-0361 CHICÁGO, ILL. Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 ☑ No Director WICOMICO SALISBURY 10f. Zip Code 10g. Citizen of Whal Country? 10e Street and Number USA 21801 440 PENNSYLVANIA AVENUE Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 1950— If Yes, Give Year or Dates: 1952 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 Yes 2 XNo Specify: WHITE 3 € Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AUTO SHOP MECHANIC 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ANGELINE BANKA STANLEY KICHARSKI ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 710 CAMDEN AVENUE, SALISBURY, MARYLAND 21801 RACHEL TERZICH-DAUGHTER IN LAW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) CREMATORY OF DELMARVA 05 18 2005 DELMAR, DELAWARE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 Visa Lecelles 23a. P. rt1. Enter the disease, or complications that caused the softh. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List may one cause on each line. Approximate Interval Betwo Onset and De and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ir jury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day detached for in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ed bluods 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 Yes 2 No 2 1 N 1 TYes filled in by the funeral director. 25. Was case referred to medical exampler?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Inpatient 2 ER/Outpatieni 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel I 1 Centifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Heddel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check onl 29c. License number 29d. Date/signed (Month, Day, Year) 29b. Signature and title of 30. Name and address of personant completed cause of death (Item 23a) (Type, Print) GERON ST. SZUSBURY MID 2180 CHRIS SAYDE MD. 100 31. Date filed (Month, Day, Year) State Registrar MAY 1 9 2005

DHMH 17 Rev 1/2001

ORIGINAL

CPM 05-03378 Teri Keim

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** TERI 16:20 LYNN KEIM May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Peninsula Regional Medical Center Salisbury Wicomico If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □XF 213-70-8782 46 Yrs. Director <u>JAN.16,1959</u> DELAWARE Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other then "natural", or items 23a or 28e-f show other treumstic event. It is Medical Examiner must be notified at DELAWARE SUSSEX SEAFORD Y☐Yes 2☐No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 726 WEST IVY DRIVE 19973 AMERICA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ent: If Item 27 is marked other then "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education STATE Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DIVISION OF CHILD CASE WORKER 12 SUPPORT SERVICES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LUCIAN T. JONES RUTH CONAWAY ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MELISSA R. KEIM DAUGHTER 726 W.IVY DRIVE SEAFORD, DELAWARE 19973 Method of Disposition

| 20b. Place of Disposition (Name of 1 | Burial | 2 | Kremation | 3 | Removal from State ASTERM: cSTOREther place) 20c. Location - City or Town, State 20a. Method of Disposition 5/18/05 permit. Page Department of Importent: If any injury or once. LEWES, DELAWARE ^ 4 □ Donation 5 Other (Specify) CREMATORIUM 21. Signature of <sup>™</sup>WATSON YATES FUNERAL HOME, SEAFORD, DELAWARE 19973 art1. Enter in diseas shock, or healt failure. Approximate Interval Between Onset and Death sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician 1 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ Yes 2 □ No Yes Yes 2 No Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ů 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred motorcy ele Decoused diving motorcy ele Callided WI Truck 27. Manner of Death 28b. Time of Certification: □Natural Injury 5 Pending 15/05 death. 10:50 A M 1 Tes investigation 2 Accident after death 6 Could not be determined 3 🗆 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 12922 Laure Roll 4 Homicide in 24 hours the Funerel Directory roac Courel, DE 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Viithin 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number OCME May 16, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt)

Registrar

DHMH 17 Rev 1/2001

MAY 1 9 2005 31. Date filed (Month,

MAT

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32. Resistrar's Signature

111 Penn Street

Baltimore, Maryland 21201

			For State Registra MEND#20b, coerFHE	State of Maryland	d / Depa	artment of H			P	105	18545
			Registrant LIV #200, QUELTIL     Decedent's Name (First, Middle, Last)	7/23/03 <b>,B</b> W,PDO	061	uncate of L	Jealii	2. Date of Dea	eg. No.		3. Time of Death
	Physicia /Medic		LAWRENCE M	. KELLY, SE	ł			MAY 1	5, Day 20	05 Year	2:15 A M
	Examin		4a. Facility Name (If not institution, give str			4b. City, Town, or			4c. Cou	nty of Deatl	1
			Holy Cross Hosp				Spring If Under 24 Hrs.				OMERY
	Funeral Director		5. Social Security Number 6. Sex 120-38-4944	7. Age (In yrs. I	• • • • • • • • • • • • • • • • • • • •	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day	; <sub>Year)</sub> 3 <b>,</b> 194	9. Birth	nplace (State or Foreign untry) Maryland
			Usual Residence of Decedent					Aug. I	3,134	+	Maryrand
	arylan show	_	10a. State 10b. County MD Montgor		r, Town or Lo	cation ncervill					10d. Inside City Limits
	he Mi	ecto		пету		.,			IO- Citi	414/5-4-0-	MTXYes 2 No
	with t	Funeral Director	10e. Street and Number 16521 Batson H	Road		10f. Zip Code	0868		l0g. Citizen	S.A	-
	death ms 23	nera		2. Was Decedent Ever in U.	S. 13.	Was Decedent of His f Yes, specify Cubar		ecify Yes or No-	14. F	lace - Ame	ncan Indian,
ဖွ	after or ite	Fur	1 Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 ②XNo If Yes, Give		_	Specify:	Hican, etc.)		llack, White cify: ${ m Bl}$	_
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Medical Examination must be rotified at	d by	3 Widowed 4 Divorced	Year or Dates:							
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212	e filed within al Hygiene. i other than " vent, the Me	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		Self-emp			Lawn	Care	Service
ğ	be filed within 72 hours after death with the Marylar hat Hygiene. ad other than "natural", or litems 23s or 28s-f show other than "natural", or cliffied at event, the Medical Examinar must be collified at	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,	Maiden Sum	ame)	
yla	should be nd Mental marked o	70	Norman E. Kelly					Mae He			
Maryland	perrii. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic es		19a. Informant's Name/Relationship (Type Jeanette W. Kell	•	1	ng Address <i>(Street</i> a			-		ip Code) MD 20868
ē,	s 1 an I Heal Item 2 pther	(8	20a. Method of Disposition						20c. Location		
ê	Page nr: F		1 ➡Burial 2 ☐ Cremation 3 ☐ Rel 1 ☐ Donation 5 ☐ Other (Specify)	moval from State	ate of,	sition (Name of natory or other place Heaven	Park 5/	23/05	ilver	Sprir	19MD
Baltimore,	rmit. spartm porta y inju		21. Si mature of Funeral Service Licensee		22	. Name and Addres	s of Facility SN	OWDEN :	FUNER	AL H	OME, P.A.
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П			23a. Part1. Enter the disease, or complice shock, or heart fallure. List only one	ations that caused the death cause on each line.	. Do not ent	er the mode of dying	, such as cardiac o	or respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Sepsis		-					Davs
п	Examiner			Due to (or as a consequ							12.00000
	<b>&gt;</b>	Jer	Sequentially list conditions, b.	Respirat	Janea Hi:	rallure					Days
	ocuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.								
8760,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):						
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Box (	death certific e attending p id for use as i	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c	c. If yes, outcome of pregna					23d.	Date of deli	very
	death	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		Ectopic pregnancy Other (specify)				Month	Day Year
P.0	at the de d by the a etached	Phys	9 Unknown					00 0141			
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions control  Peripheral Vas			nderlying cause give	n in Part I.				the cause of death?
Sor	w require been sig should b	etec	Telipheral val	304141 3136							topsy findings available
Records,	0 = 0	Completed						24a. Was a autops perfor	med?	prior to death?	completion of cause of
Vital	ician: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of Death	1 Yes		1 🗆 Yes	2 🗆 No
₹ <	Ø .⊵	To B	examiner? 1 ☐ Yes 2 🛣 No	spital: Minpatient 2 🗆	ER/Outpatier	t 3 DOA Othe				ther (Spec	ify)
n of	ing Ph kter th uneral		27. Manner of Death 1   Matural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work		28d. Describe h	ow injury occ	urred	
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Ď.	or Atten after deat Director:	ertif	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	/)	eet, ractory, onice		City or Town		noor Gring	rai noute ivamber,
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	Sta		Suresh K. Gupta 31. Date filed (Month, Day, Year)	32 Registrar's Signa	) L Ge(	orgia Ve	., S11V	er spr	Ing,	MD 2	0902

			For State Registrar		State	of Ma	aryland /	/ Depa	rtment o	of He	alth an		ntal Hy	giene Reg. No.	005	<u>.</u>	85	46
	Physicia	ın	1. Decedent's Name Robert Bra										Date of Dea Month May 17,	Day		ear	Time of	Death p M
	/Medic Examin		4a. Facility Name (If I		give street and nu	mber)			В	ethes		Death	Liy 177		County of I	Death omery		
	Funeral Director		5. Social Security Nur 314-26-8509		i,Sex 1	7. Age	e (In yrs. last 78	birthday) Yrs.	If Under 1 Months E	Year Days	If Under 24 Hours A	Min.	Date of Birt (Month, Day ov. 15,	h y, Ye <i>ar)</i> 1926	9.	Birthplace Country) Indi	(State or ana	Foreign
	iryiand thow			ecedent 10b. County N/A			10c. City, T	own or Lo Washi									nside Cit	
	th the Ma or 28e-f s e notifie	Director	DC 10e. Street and Num	per				Wasill	10f. Zip Co							at Country?	Tes	2% No
	death wi	Funerai D	4901 Com	ecticut	Avenue, M	edent l	Ever in U.S.	13. V	Vas Deceder Yes, specify	0008	oanic Origin	? (Specif	y Yes or No			American In	dian,	
	036 ours after ral', or ite	Ď	Never Marrie 3 ☐ Widowed 4		d 1₹ Yes	2 🗆 N	<sup>No</sup> 1945 <b>–</b> 47	1	Tes, specify		Specify:	derio riii	zan, etc.)		Specify: W			
	215-0 thin 72 ho en "natu	Completed	(Specif		grade completed) College (			(Give life. L	lent's Usual C kind of work of OO NOT use	done du retired)	ring most of	f working				ess/Industr	/	
	e filed will Hygien other th	Be Con	17. Father's Name (F	irst, Middle, La	ast)			Mec	hanical				First, Middle.	Maiden		ing		
	should by and Menta marked	Tof	Frank Lune 19a. Informant's Nar	•	p (Type, Print)		1	19b. Mailin	g Address (S	Street an	d Number o		nette M			ate, Zip Code	e)	
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or items 23s or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at once.			sition Cremation 3	3 □Removal from	State	ceme	e of Dispo etery, cren	Kenyon S sition (Name natory or othe Church	of er place)		Dat Mar	y 21,		cation - Cit	y or Town, S	State	
	Baltim permit. Pa Departmer Importent any injury once.		4 □ Donation 5			,	Sc. I	Fr	Name and ancis J	Address	of Facility Lins Fu	unera	1 Home			linois 0901		
105 2350 Pm	Medical Examiner and he burial-transit	icai Examiner	23a. Parf1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death)  Sequentially list conif any, leading to immediate Cause (Disease or in that initiated events resulting in death) Leading in death	failure. List or inal ditions, lediate ing	a	each lir (or as (or as	a consequen	ce of):	'5/S							Inte	rval Betvet and C	reen leath
5/16	Box 68 death certifica e attending ph	Physician/Medi	IF FEMALE: 23b. Was decedent in the past 12 n 1 □ Yes 2 □ 9 □ Unknown	onths?		birth nant at	of pregnancy 2 Fetal de time of death	ath 3	Ectopic preg Other (spec					2	23d. Date o Month	,	*	'ear
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Sobe	I Recor	Completed											24a. Was	an osy rmed?	24b. Wer prio dea	re autopsy fi	ndings a	available
~	f Vital yeicien: Tis certificate director, pa	To Be	25. Was case referre examiner?	d to medical	Hospital:	Inpatie	ent 2∐ER	/Outpatien	t 3 DOA	_			Check only o		S ☐ Other (	(Specify)		
uney	ision ttending death. rtor: After	Certification:	27. Manne of Death  1 Natural  2 Accident  3 Suicide	5 Pending investiga	t be 200 Blac		ry 28 y Yea <i>r)</i> ury - At home	b. Time of Injury	М	. Injury a Work? 1 🗌 Ye	at es 2⊡No	28	d. Describe h	now injur	y occurred		ite Numi	ber
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•	30+1	Σ	29b. Signature and t	tie of certifier	Zmo	7	Bas	M		D 0		71.	24			y Day,	,	
			30. Name and addre	ss of person w Bao, M. D.	ho completed cau					erman	ntown, I	MD 20	874					
	Sta Registr		31. Date filed (Month	Day, Year) 1 8 20	- 43	Registr	ar's Signature	food	r)									

			For State Registrar	State o	of Marylan		artmen rtificat			and Mo		giene	The part year	
			Decedent's Name (First, Middle, La	st)							2. Date of Dea	ath 🤚	<del>UU5</del>	3. Time of Death/
	Physicia /Medic		Nona Leah	LANSKY							Month May 16	Day 20	Year 205	4:15 A M
	Examin		4a. Facility Name (If not institution, given	e street and nu	mber)		4b. City,	Town, or	Location o	f Death		4c. (	County of Death	
			Lorien Mt. Airy		~ A . //-			Mt.	Airy If Under 2	24 Hrs.			Carroll	· · · · · · · · · · · · · · · · · · ·
	Funeral Director		5. Social Security Number 6. S 216-96-0344	ex I□M 2 <b>X</b> □F	7. Age (In yrs. 57	Yrs.	If Under Months	Days	Hours		8. Date of Birt Month, Day March I	1 <sup>Year)</sup> 1	948 Rus	place (State or Foreign ntry) SIA
			Usual Residence of Decedent											
	anylan ehow	_	10a State Carroll		10c. Cit	y, Town or Lo Mt 。A:	cation Lry							10d. Inside City Limits 1 A Yes 2 No
	he M.	Director	10e. Street and Number				104.7:-	Carlo				10a Citia	zen of What Cou	
	within 72 hours after death with the Maryland ene. Itan "natural", or itama 23a or 28a-f ehow he Medical Examinar must be notified at		713 Midway Ave.				10f. Zip	1771				-	U.S.A.	ntry r
	death rms 2;	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.	Was Dece	ent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	. 1	14. Race - Ameri	
စ္	or ita	F	1 Never Married 2 Married	Armed For 1 ☐ Yes If Yes, G	2 X No		ryes, spek 1 □ Yes		n, Mexican Specify:	i, Puerto F	Hican, etc.)		Black, White,	
	nours ural',	d by	3 ☐ Widowed 4 ☒ Divorced	Year or E	Dates:	, 1							Specify: Wh	
-5	n 72 in nat	olete	15. Decedent's E (Specify only highest gr	ade completed)		16a. Dece (Give	dent's Usua kind of wo DO NOT u	al Occupa rk done d se retired	ation du <i>ring most</i> ')	t of workin	ng	16b. Kin	nd of Business/Ir	ndustry
212	with jiene. r ther	Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)	Optio			,			Op	itical	
9	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene .  I amarked other than "natural", or flame 23a or 28a-f show fearmarked other than "natural", or flame 23a or 28a-f show raumatic event, the Medical Examinar must be notified at	Bec	17. Father's Name (First, Middle, Last Lev Gold	)							(First, Middle,		,	
<u>X</u>	should be nd Mental marked umatic ev	To									nya Mir			
Mar	id 2 sh Ith and 27 ie m traum		19a Informant's Name/Relationship Miriam Lansky	Туре, Print) daught	er	19b. Maili	Address 21 Fa	airoa	a <i>nd N</i> umbe ak Dr	ive,	Silver	sr, City or Spr	ing, MD	20902
<u>ი</u>	s 1 and f Health itam 27 other to	- 3	20a. Method of Disposition			 Place of Dispo cemetery, crei	sition (Nar	ne of	el l	D	ate	20c. Loc	cation - City or T	own, State
Ë	Pages nent of 1 ant: If its		1 Burial 2 □ Cremation 3 [ '4 □ Donation 5 □ Other (Speci		State Mt.	Leband	n Cei	nete	ry Ma	y 17	, 2005	Ade	lphi, M	D
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should b Department of Health and Menit important: If Itam 27 le marked any Injury of other traumatic e ones.		21. Signature of Funeral Service Lice	nsee /	der	22	2. Name ar	nd Addres	s of Facilit	y Toro	chinsky	Heb	rew Fund	eral Home
			23a. Part1. Enter the disease, or con	plications that	caused the deat								11, DC 21	Approximate Interval Between
E	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	One cause		TIP	LE	<	CIE	20	2 120			Onset and Death
	/Medical		resulting in death)	a Due to	(or as a conseq									10 727113
В	Examiner	L	Sequentially list conditions,	b	(									
	ted 1sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	uence or):								
	axecul al-trar	Examiner	that initiated events resulting in death) Last	c Due to	(or as a conseq	uence of):								
8760	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical [	(	d										
φ	ntificat ng phy as th	Aedi	IF FEMALE:											
Вох	leath certific attending p I for use as	an/h	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome of pregna birth 2 - Feta	I death 3	Ectopic p					2	23d. Date of deliv Month	ery Day Year
o.	res that lha das igned by the a be detached for	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Preg 9□ Unkr	nant at time of d nown	leath 5	Other (sp	pecify)						,
О.	that II ed by detac	/Ph	Part II. Other significant conditions	contributing to	death but not res	ulting in the u	nderlying o	ause give	en in Part I.		23e. Did to	obacco us	se contribute to	the cause of death?
ds	quires n sign ald be	d by	RESPINA-	1009	FAIL	une					101	Yes 2 €	No 3□ Pro	bably 4 Unknown
000	sw require s been sig	Completed		,							24a. Was		24b. Were aut	opsy findings available ompletion of cause of
Re	The lav	E O									autor perfo	rmed? 2 PNo	↑ death?	2ENo
ta	iiclan: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o			
<u></u>	hysic this ce	မ	1 ☐ Yes 2 💆 No		Inpatient 2			- 1	44E NU	-			Other (Speci	fy)
Division of Vital Records,	ling P	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending		of Injury nth, Day Year)	28b. Time o Injury	f i	28c. Injun Worl	yat k? Yes 2□		28d. Describe I	how injury	y occurred	
S	death ctor: y the	ficat	2 Accident investigate 3 Suicide 6 Could not	00 01-	e of Injury - At h	ome, farm, st			183 2		28f. Location (	Street and	d Number or Rur	al Route Number.
<u>&gt;</u>	after after Dira	Certification:	4 Homicide determined	build	ding, etc. (Specia	fy)		,,			City or Tov			
	To the Hospital or Atlanding Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 Certifying P	hysician: To th	best of my kno	owledge, deat	h occurred	at the tin	ne, date an	id place, a	and due to the	cause(s)	and manner as	stated.
	the H in 24 tha Fi	ledical	one)	and ma	nner stated.	ation and/or in				THE OCCUPIE				
	To To	Σ	29b. Signature and title of certifier	LI	1 -		29		e number	ai-		290. Date	e signed (Month,	Day, Year)
,	2		20 1	complaint :	no of doub (los	m (13 c) /T -	Pric *	1)	- 2	11.	2	·> / I	2103	
			30. Name and address of person who	/ -	64 UPC	ii zsa) (Type,	70W1	u ri	48.	rn2	Deniu	1 . h	nD 21	702
	Sta	ate	31. Date filed (Month, Day, Year)		Registrar's Sign	ature	- M a	•					<i>y</i> -	
	Regist	rar	MAY 182	005	Registrar's Sign	F 190	and I							

strar

State of Maryland / Department of Health and Mental Hygiene

Other: Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

2 🙀 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

May 13, 2005

28d. Describe how injury occurred

			- State Ragistrar		Cei	tificate of Death	7	Reg. No.	0 1	0040
ı	Dhysisi		1. Decedent's Name (First, Middle,	Last)			2. Date of D Month	eath Day	Year 3.	Time of Death
	Physici /Medio		Ethel Ke	a	Lewis		May 12	, 2005	3	3:20 P M
	Examir		4a. Facility Name (If not institution,			4b. City, Town, or Location	of Death	4c. County		
			St. Catherine's		ter	Emmitsburg			rederio	:k
	Funeral		, , , , , , , , , , , , , , , , , , , ,	5. Sex 7. Age 1 ☐ M 2 ☐ F	(In yrs. last birthday)	If Under 1 Year If Under Months Days Hours	r 24 Hrs. 8. Date of Bi	irth ay, Year) <b>6,1926</b>	Birthplace Country)	(State or Foreign
	Director		220-18-3177	,	79 Yrs.		Feb. 2	6,1926	Marylai	ıd
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation			10d. I	nside City Limits
	sho	2							i	Yes 2 No
	he N	Directo	Maryland Freder  10e. Street and Number	1CK	Thurmont			40- 00:		
	with the party of			F	3	10f. Zip Code		10g. Citizen of W		
	death with the Maryland sms 23s or 28s-f show r must be rolliked at	Funeral	12849 Catoctin			21788		US		
	er de Item	nu	11. Marital Status	12. Was Decedent I Armed Forces?	] 1	Was Decedent of Hispanic O f Yes, specify Cuban, Mexica	rigin? (Specify Yes or N an, Puerto Rican, etc.)	0- 14. Hace Blac	e - American Ir k, White, etc.	idian,
9	hours after turaf', or Ite	by F	1 ☐ Never Married 2 🔀 Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 ██\ If Yes, Give Year or Dates:		I∐Yes 2XNo Specify	<i>r</i> :	Specify	Whit	:e
3	hour tura		15. Decedent's		16a Decor	dent's Usual Occupation		16b. Kind of Bu	cinoco/Industr	
9500-61212	filed within 72 Hygiene. Ither than "nal ent, the Medic	Completed	(Specify only highest	grade completed)	(Give	kind of work done during mo	st of working	TOB. KING OF BU	3111633/111003(1	у
7	with ene. thar	E	Elementary/Secondary (0-12)	College (1-4or 5	+)	omemaker		Own	n Home	
Ö	be filed within 72 hours after death with the Marylan lal Hygiene. d other than "naturaf", or Items 23a or 28a-f show event, the Medical Examinat must be notified at		17. Father's Name (First, Middle, La	ast)			ner's Name (First, Middle			
Maryland		To Be	Maurice	William	Wood	E	. Ruth		Toms	
2	s 1 and 2 should by f Health and Menta them 27 Is marked other traumatic events.	1	19a. Informant's Name/Relationshi	n (Type Print)	19b Mailir	ng Address (Street and Numb	her or Bural Boute Numi	her City or Town	State Zin Con	(a)
<u>8</u>	d 2 3 Than				53345		22:1	225 0	DESWER .	
	l and fealth im 27 her ti		Raymond Lewis, I	I/ Son	20b. Place of Dispo	Manse Road,	Hagersto Date			State
<u></u>			1 ₩ Burial 2 □ Cremation	B □Removal from State	cemetery, crer	natory or other place)		20c. Location -		
Ξ	Pages ment of ant: if it		'4 ☐ Donation 5 ☐ Other (Spe		Resthaven	Mem. Gards	5/18/2005	Freder	ick, MI	)
Baltimore,	permit. Page Department of Important: ff any injury or ance.		21. Signature of Funeral Service Li	censee	22	Name and Address of Faci	Stauffer	Funeral 1	Home. H	PA.
Ц	20 E 9 9		Koguly	il les					21788	
			23a. Part L Enter the disease, or c shock, or wart failure. List o	omplications that caused nly one cause on each lin	the death. Do not ent	er the mode of dying, such a	s cardiac or respiratory	arrest,	Inte	oroximate erval Between
	Physician		Immediate Cause (Final disease or condition	MRSA					3	weeks
	/Medical		resulting in death)	Due to (or as	a consequence of):					
	Examiner			Bilate	eral Pneumo	onia			3 1	weeks
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	Endst	age COPD				10	Years
<u> </u>	eath certificate be executed attending physician and for use as the burial-transit	Exa	resulting in death) Last	Due to (or as	a consequence of):		·			
9	e be /sicia e bur	cai		d						
68/60,	ificat g phy as th	n/Medicai								
×		N N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy	_		23d. Date	e of delivery	
ă	atte		in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant at	2 Fetal death 3 time of death 5	Ectopic pregnancy Other (specify)		Mor		Year
o.	the c y the	in the past 12 months?  1  Yes 2 No 9 Unknown  1  Other significant conditions contributing to death but not resulting in the underlying course gives in Part I								
2	requires that the death seen signed by the atter hould be detached for t	y PI	Part II. Other significant condition	s contributing to death b	ut not resulting in the u	nderlying cause given in Part	I. 23e. Did	tobacco use contr	ibute to the ca	use of death?
ds	uires t signe Id be d	d by					11	Yes 2 No	3 🗀 Probably	4 Unknown
ecords,	w require been si should b	Completed					24- 46	0.45	Masa sutar - : 1	Unations assets to the
He	The law ate has b page 2 sl	du					24a. Wa auto	opsy p	vere autopsy t rior to <i>co</i> mple leath?	findings available tion of cause of
_	Th ate pag	Ö							Yes 2	No

Division of Vital R

To the Hospital or Attending Physician: The Is within 24 hours after death.

To the Funeral Director: After this certificate ha completely filled in by the funeral director, page?

Certification: To

Medical

State

31. Date filed (Month, Day, Year)

25. Was case referred to medical examiner?

5 Pending

investigation 6 Could not be determined

1 ☐ Yes 2 No

27. Manner of Death

1 XNaturai 2 ☐ Accident

3 🗌 Suicide

4 🗌 Homicide

(Check only one)

29b. Signature and title of certifie

strar's Signature

3 DOA

28c. Injury at Work?

1 X Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Н0044037

1 ☐ Yes 2 ☐ No

Dr. Bonita Portier 52 Water Street, Thurmont, MD 21788

Hospital: 1 ☐ Inpatient

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

Registrar

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

((2)	07		State of Manyland				•	-	Die.	
		-	- For Amend Item 1&Unpend Item 23a	kZ7 <sup>P</sup> j	per me G	545"7-21-0 Death	5 tas	Reg. No.	05 185	49
	Dhusisi		Decedent's Name (First, Middle, Last)				2. Date of De		3. Time of D	eath
	Physicia /Medic		Jessica Gisselle Pavia	- Mor			May 24	, 2005	3:50 a	М
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town,	or Location of Death		4c. County	of Death	
2	Funeral		Sinai Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday)	Balti If Under 1 Year	r If Under 24 Hrs.	8. Date of Bir	th	Birthplace (State or F Country)	Foreign
9	Director		217-71-9670 ¹□M 2ĀF	Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da 2/01/	2005	Maryland	
	put 🔭		Usual Residence of Decedent         10c. City.           10a. State         10b. County         10c. City.	Town or Lo	cation				10d. Inside City	Limite
	Aaryla f aho	ō			ille				1 Tes 2	
	r 28a-	Funeral Director	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Country?	
	th with	alD	14 Warven Park Apt.C-2		2120	8		US	βA	
	r dea lema er m	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of f Yes, specify Cui	Hispanic Origin? (Sp ban, Mexican, Puert	pecify Yes or No Rican, etc.)	- 14. Rac Bla	ce - American Indian, ck, White, etc.	
36	rs afte	by Ft	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Year or Dates:		1 √2 Yes 2 □ No	Specify: Mex	ico	Specif	y: White	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or itema 23e or 28a-f ahow La Modical Exeminer must be motified at		15. Decedent's Education	16a. Dece	dent's Usual Occu	pation		16b. Kind of B	usiness/Industry	
215	thin 7 e. an "n Me.1	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life.	NITE OF WORK CONG DO NOT use retire	a during most of wor ed)	ang			
21	filed wi Hygien other th		O (First Middle Look)	nc	ne	40.14-11-1-11-	- (First Ational)	none		
and	ntal Hed ot	Be	17. Father's Name (First, Middle, Last)  Jesus Maya Vargas			18. Mother's Nam	<sub>е (First, Middle,</sub> Pavia		ne)	
Ž	should ind Men ind Men inarke	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Stree	et and Number or Ru			State, Zip Code)	
	7 ta		Jenny Pavia Moran/Mother		-			•	lle,Md212	80
Baltimore,	permit, Pages 1 am Department of Heali Important: If Item 2 any injury of other		Cen	netery, crer	sition (Name of natory or other pla	ace)	Date	20c. Location	- City or Town, State Ina Guajaca	а.
<u>m</u>	Page ment and ury o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State • 4 ☐ Donation 5 ☐ Other (Specify)	ıteor	Munic	ipal6/04	/05	Mexi		<u>~,</u>
3alt	permit, Pages Department of H important: If ite any injury or of		21. Signalur / Pyheral Service Mensee	PF	Name and Addr	RINALDI	FUNER	AL SER	VICE, P.A.	
	40240		23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not en	41 Col	umbia Bl	vd, Sil	ver Sp	ring, Md20	910
				DO NOT GITE	er me mode or dy	ing, such as cardiac	or respiratory a	11631,	Interval Betwee	en eath
7	/Medical		disease or condition resulting in death)  Pneumonia  a.  Due to (or as a consequence)	ance of):						
	Examiner			,						
	D H	Iner	Sequentially list conditions, if any Leong to immediate cause. Enter Underlying Cause (Disease or injury	nce of:						
	e be executed /sician and e burial-transii	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a conseque	ence of):						
760,	sician buria	calE								
68			d							
Вох	th cert endin r use	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal of		Ectopic pregnan	cv			ite of delivery	
-	e dea the att	sici	in the past 12 months?  1 □ Yes 2 No 9 □ Unknown  1 □ Ves 2 No		Other (specify)		-	Mic	onth Day Ye	ar
P.O.	Attending Physician: The law requires that the death certifica rideath. r death. ector: After this certificate has been signed by the attending ph. by the funeral director, page 2 should be detached for use as th	Phy	Part II. Other significant conditions contributing to death but not result	ing in the u	nderlving cause g	iven in Part I.	23e. Did t	obacco use con	tribute to the cause of dea	ath?
Vital Records,	uires n sign	d by			, ,		10	Yes 2 📉 o	3 Probably 4 Un	known
00	s beer	lete					24a. Was	an 24b.	Were autopsy findings av	/ailable
Re	The lav	Completed					autor perfo	rmed?	prior to completion of cau death? 1 A Yes 2 \( \times \) No	use of
ital	strifice ctor, p	Be C	25. Was case referred to medical examiner?			26. Place of Dea				
	Physic this co	ဥ	1 X Yes 2 No Hospital: 1 ☐ Inpatient 2x E	R/Outpatier	IL SELDOA			dence 6 Oth		
on (	ding F	tlon:	1 Natural 5 Pending (Month, Day Year)	8b. Time of Injury	W	ury at ork? ] Yes 2  No	28d. Describe	how injury occur	ted	
Division of	Attender death	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At hom	ie, farm, str					ber or Rural Route Numbe	9 <i>r</i> ,
Ö	al or safter	Cert	4 Homicide building, etc. (Specify)		,,		City or To	vn, State)		
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier (Check only (C	edge, deat	h occurred at the	time, date and place	and due to the	cause(s) and ma	anner as stated.	
	the H hin 24 the F nplete	Medical	one) and manner stated.	TI ATTOVOT TIT		nse number				
	To Cor		29b. Signature and title of certifier	116	OCI			May 24	d (Month, Day, Year)  2005	
	\		30. Name and address of person who completed cause of death (Hem 2	23a) (Type	Print)			-		
			Tasha Z Greenborg M.D.	11	1 Penn S	Street Ba	ltimore	, Maryla	and 21201	
	Sta		31. Date filed (Month, Day, Year) 37 Registrar's Signatu	Te Sp	and B					
	Registi	ar	MAY 2 7 2005 Breve B	1500	WALK!					

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Certificate of		Re	g. No.2 () (	5 18550
	Physician	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day	3. Time of Death Year 005 10 :08 A
	/Medical	Lawrence D. McDonald  4a Facility Name (If not institution, give street and number)	4b. City, Town, or Lo		13, 2 4c. County o	
	Examiner	8500 Edmonston Road	College 1		-	George's
Ī	Funeral Director	5. Social Security Number 577-34-4671 6. Sex 7. Age (In yrs. last birthday) 1 Months Definition of Security Number 7. Age (In yrs. last birthday) 1 Months Definition of Security Number 1 Yrs.		8. Date of Birth Dec. 8,	1 <b>9</b> 28	9. Birthplace (State or Foreign Washington, DC
	p a	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Maryle f sho	MD Prince George's College Park				1≰2 Yes 2 □ No
	vith the Mar or 28s-f sl be notified Director	10e. Street and Number 10f. Zip Cod	de	10	g. Citizen of W	hat Country?
	th wit		740		nited S	
Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Medical Exaciner must be notified at pines.  To Be Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U,S. Armed Forces?  13. Was Decedent If Yes, specify 0  14. Was Decedent Ever in U,S. Armed Forces?  15. Was Decedent Ever in U,S. Armed Forces?  16. Yes, Give Year or Dates:	of Hispanic Origin? (Spe Cuban, Mexican, Puerto No <i>Specify:</i>	ecify Yes or No- Rican, etc.)	Black	- American Indian, , White, etc. White
5-0	72 ho	15. Decedent's Education 16a. Decedent's Usual O. (Specify only highest grade completed) (Give kind of work de	ccupation one during most of worki atired)	ing	6b. Kind of Bus	siness/Industry
121	ed within 72 hours a ygiene. Ner than "natural", ont, the Mandral Exant. Completed by	Elementary/Secondary (0-12) College (1-4or 5+) Entrepreneu			Privat	e
d 2	Hygie of the of	12 17. Father's Name ( <i>First, Middle, Last</i> )	18. Mother's Name	e (First, Middle, N	fa <i>iden Surn</i> ame	)
/lan	Mental H Arked ott arked ott artic aven	Daniel McDonald		a ( unob		
Aan	2 sho and h is ma	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (St				
	1 and Health sm 27 ther t	Jean Shugars / Daughter 30400 Comand 20a. Method of Disposition 20b. Place of Disposition (Name cometer), crematory or other				MD 20622 Dity or Town, State
Baltimore,	Pages ment of I ant: If ite	4 Donation 5 Other (Specify)	netery  ddress of Facility For	5/17/200		twood, MD
Balt	permit Depart Import any In		densburg Ro			
		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.	dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician	,				Onset and Death
Ч	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Cornary Artery Disease			_	<u> </u>
	ř ř	Due to (or as e consequence of):				
	ficate be executed physician and ts the bunal-transit edical Examiner	Sequentially list conditions,  Due to (or as a consequence of):				
90,	oe exe cian al ourial-t	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
68760,	physic sthe b	that initiated events Due to (or as a consequence of): resulting in death) Last				
Box (	= 0,0	d				
	death e ette ad for sicia	Part II. Other significant conditions contributing to death but not resulting in the underlying caus	e given in Part I.	23b. Did to	bacco use con	tribute to the ceuse of deeth?
P.0	at the death certi d by the ettending etached for use a Physician/M			1 □ Ye	s 2 No	3 ☐ Probably 4 ☐ Unknown
Records,	The law requires that the death certificate be executed ate has been signed by the ettending physician and page 2 should be detached for use as the bunal-transit Completed by Physician/Medical Examir			24a. Was a	n autopsy ned?	24b. Were autopsy findings available prior to completion of cause of death?
Re	The law ate has by page 2 s			1 □ Ye	es 2 (3 No	1 □ Yes 2 □ No
ital	stor, pa	25. Was case referred to medical	26. Place of Deat	h (Check only on	е)	
). 	Physician: this certific ral director.	examiner?  11 Yes 2 No  Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA	Other: 4 Nursing Ho			
o no	ing Pl	142 Natural Sign ending.	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurre	Dec Dec
Division of Vital	tal or Attending P is after death. el Director: After t led in by the funer? Certification:	2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, of		28f. Location (St	reet and Numbe	er or Rural Route Number,
O.	al or A s after I Dire ed in b	4 ☐ Homicide building, efc. (Specify)		City or Towr	, State)	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	29a. Certifier (Check only one)  1/1 Crtifying Physicien: To the best of my knowledge, death occurred at the control occurred at the control occurred at the control o	ne time, date and place, my opinion, death occur	and due to the cared at the time, d	ause(s) and mar ate and place, a	nner as stated. nd due to the cause(s)
	orthe		cense number	2	9d. Date signed	(Month, Day, Yeer)
	F S F Ö	Jehn Bem Sten MD	138451		May	16,2005
	(5)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	. D.1 T	7 3	m 20707	
K		Jeffrey S. Garbis, M.D. 7350 Van Du	sen Kd. L	aurel, M	ш ∠0/0/	
	State Registrar	31. Date filed (Month, Day, Year)  MAY 1 9 2005				

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** 2005 05 16 3:10 Virginia Mashino /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Calvert Calvert Memorial Hospital Prince Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🕱 F Months Days Hours Yrs. 51 Washington, DC Director 07/28/1953 216-58-7432 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Events and some once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes \$ No **Funeral Director** Maryland Calvert <u>Huntingtown</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 75 Walton Road 20639 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ☐Yes 2X No If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify. Specify: δ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) Medical Billing <u>Health Care</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be H. Bruce Edkins Margaret E. Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 75 Walton Rd. Huntingtown, MD 20639 Gary B. Mashino/Husband 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Fort Lincoln Cemetery 5/21/2005 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityFort Lincoln Funeral Home Cuane 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cabse on each line. 3401 Bladensburg Rd. Brentwood, MD 20722 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTRITC SMALL CELL CANCER OF THE LUNG /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner sician and burial-transi The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown DEHYDRATION, THROMBUCYTOPENIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 \( \tau \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) 1 ☐ Yes 2 No Certification: To 1 X Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: , 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide after within 24 hours a (Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) PRINCE FREDERICK, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL DR, SUITE A MOODYIMD 110 Glynis 31. Date filed (Month, Day, Year) Registrar's Signature State MAY 1 9 2005 Registrar

		•	1 - Stata Registrar	State of Marylan	•	artment of H			giene Reg. No. 2   1   11	from a fine from the first
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Louise C. Mo	organ				2. Date of Dea Month May		3: Time of beath (
	Examin		4a. Facility Name (If not institution, give s Washington Adv	ventist Hospi			Location of Deat			gomery
	Funeral Director		5. Social Security Number 6. Sex 577-30-6152  Usual Residence of Decedent	7. Age (In yrs. 90	Vec	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day Aug. 30	y, Year)	Birthplace (State or Foreign Country) Wash., DC
	Maryland a-f show	ctor	10a. State 10b. County  DC	10c. Cit	y, Town or Lo		Vashingt	on		10d. Inside City Limits 1X Yes 2 □ No
	with the e or 28	Director	10e. Street and Number	1 N E		10f. Zip Code	20018		10g. Citizen of What	Country?
36	toges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23e or 28e-f show or other traumetic event, the Medical Examinational Le muilling at	by Funeral	3199½ Apple Ro  11. Marital Status  1 □ Never Married 2 □ Married  3♀ Widowed 4 □ Divorced	2. Was Decedent Ever in U. Armed Forces? 1Yes _ 2\overline{N} No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2∏ No		Specify Yes or No- to Rican, etc.)		merican Indian,
21215-0036	ithin 72 hour le. len "natural	Completed to	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	turing most of wo	rking	16b. Kind of Busine	ess/Industry
	filed wi Hygien ther th		12th 17. Father's Name (First, Middle, Last)			Nurs		ne (First, Middle,	Priv	vate
Maryland	ould be I Mental narkad o	To Be	Henry Jol		405 14.75				el Lewis	7.0.11
	alth and 2 st		19a. Informant's Name/Relationship (Type Olivia A. Cook			-			or, City or Town, Stat  DC 2001	
Baltimore,	ages 1 a ant of He it: If itam y or oths		20a. Method of Disposition  1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State	emetery, crei	sition (Name of natory or other place		Date 21/2005	20c. Location - City	
Baltir	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other <u>20028.</u>		21. Signatur of Funeral Service License	1		emorial F Nameand Addres 4001 Ber	s of Facility	Stewart	Funeral Ho Wash., DC	ome
	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the deaffer cause on each line.	n. Do not ent					Approximate Interval Between Onset and Death
8760,	Medical Examiner bhysician and the burial-transit	dlcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inditated events resulting in death) Last	Due to (or as a conseq  Due to (or as a conseq  Due to (or as a conseq	uence on:	dial	ults			2 days
.O. Box 6	death certifii e attending j id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
Δ.	es be		Part II. Other significant conditions conditions	tributing to death but not res	ulting in the u	nderlying cause give	en in Part I.			e to the cause of death?  Probably 4 □Unknown
Vital Records,	The law ate has b page 2 s	Completed by	Stroke							
	Phyaician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	ER/Outpatier	it 3□ DOA Othe	ar.	ath (Check only or	ne) lence 6 Other (S	Proposite (
ion of	Attanding Physic death. actor: After this by the funeral di	atlon: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	28c. Injury Work	at		now injury occurred	респу
Division	tel or Attances after death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Płace of Injury - At he building, etc. (Specif		eet, factory, office		28f. Location (S City or Tow		Rural Route Number,
	To the Hospitel or Attanding I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical (		icien: To the best of my kno ler: On the basis of examina and manner stated.						
	vithin 2 To tha	Ň	29b. Signature and title of certifier	0.4.		29c. License	number	1	29d. Date signed (Me	
			Politically	moleted course of death (for	232) 0	Print	34.78		5713/	05
2	(4)		30. Name and address of person who cou	N WASHINGT	en Abi	,	SPITAL 7	ego Cateri	DIC AVENUE	TAKUNA PARE MA
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 9 2005	32. Registrar's Signa	ture See	E)				30113

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician scorae ad Martin 2005 6.25 am /Medical Facility Name (Whot institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner regional Sa Med. C comico . Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 082-24 Months Days Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County worle! 10c. City, Town or Location 10d. Inside City Limits item 27 Is marked other than "natural", or Items 23a or 28a-f ehov other traumatic event, the Medical Examinar must be notified at Easton lalbot 1 Tes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SA 21601 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Yes 2 No 1 Never Married 2 Married 1 🗆 Yes 2 📉 No Baltimore, Maryland 21215-0036 Specify: Be Completed by Specify: 3 Widowed 4 Divorced Year or Dates: White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Advertising 1 d 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be lar 0 George tharine 19a. Informan Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health : Martin aston 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation Ctr. 3 26 2005 injury or Department of Important: If any injury or 4 Donation Stevensville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Heltenbeint Newnam Funeral Home 200 S. Harrison St. Easton, MD 21601 JOHN R. MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** omolications /Medical Due to (of as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Be Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery jo 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death Day 5 Other (specify) the detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? Yes 200 No 2 🗆 No 1 Tyes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 1 🗌 Inpatient Medical Certification; To 2 No ER/Outpatient 3□ DOA 2 🗒 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ihis 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Driver of motor vehicle collide Hospital or Attending Natural 5 Pending 21:00p M death. 1 ☐ Yes 2 ☐ No 2 Accident investigation aa-a0051 after death with another motor vehicle
281. Location (Street and Number or Rural Abute Number City or Town, State) Kennedy Rd and Rt.50 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be determined filled in by 4 Homicide Road Easton, mD 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number March 25, 2005 OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Priot) Street, Baltimore, MD m.P LI

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

MAK Z & ZOUD

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2005 11:37 A May 17 Robert Edwin Miller /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 515 Brighton Dam Road Brookeville 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Days Hours Min **Funeral** 1**X**1M 2□ F Aug 4, 1934 Indiana 70 306 30 6754 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County Worle ! r 28e-f show 1 ☐ Yes 2 No Director Brookeville Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ir than "natural", or Items 23e or the Medical Examiner must be United States 20833 515 Brighton Dam Road Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? within 72 hours after ☐Yes 2X No 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify If Yes. Give þ White 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene Electronic Systems Electrical Engineer iges 1 and 2 should be filed it of Health and Mental Hygis: If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Margaret M. Walter Robert Edmund Miller ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 515 Brighton Dam Road Brookeville, MD 20833 Margaret R. Miller/Wife othar 1 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 XBurial 2 Cremation 3 Removal from State 6 permit. Page Department c importent: If any injury or 5-20-2005 Wheaton, MD Gate of Heavan Cem. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that 1 used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Metastatic Non-small Cell Lung Cancer resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 2 Fetel death Month Year 0 4☐ Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No P.O. detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☒ No 24a. Was an page 2 autopsy performed? Yes 26 No 1 Yes certificate Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 ☐ Nursing Home 5 AResidence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 2 1 Yes 2X No 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title May 18, 2005 D35635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan, M.D. 18111 Prince Philip Dr. Ste 327 Olney, MD 20832 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 9 2005 Registrar

**ORIGINAL** 

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of M	arylaric		tificate o				Reg. No	2000	18555
Ц	.Physicia		Decedent's Name (First, Middle,	ouglas J. M	cPhee					2. Date of De Month May	ath 17	2005	3. Time of Death 14:20 M
	/Medic Examin		4a. Fecility Name (If not institution,				4b. City, Town	, or Location	n of Death			. County of Deat	
			University of M					imore				None	
	Funeral Director		216 92 4547	157M 2□ E	ge (In yrs. Ia 38	ast birthday) Yrs.	If Under 1 Ye Months Day		er 24 Hrs. Min.	8. Date of Bin (Month, Da Jan 28	y, Year	9. Birt 967 Ma	thplace (State or Foreign buntry) aryland
	death with the Maryland ms 23s of 28s-f show rmust be notified at		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation		<del>_</del> _				10d. Inside City Limits
	aa-f s	Director	MD Howar	d	Ell:	icott							
	or 24	Dire	10e. Street and Number	- 7			10f. Zip Cod	.042				itizen of What Co nited St	-
	sath v	erai	10104 Nicolson	ROACI 12. Was Decedent	Ever in U.S	5. 13.1			Origin? (Spe	cify Yes or No		14. Race - Ame	
20	be filed within 72 hours after death with the Marylar tal hygiene. Id other than "naturel", or Items 23s or 28s-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Marrie  3 □ Widowed 4 □ Divorced	Armed Forces	?		Was Decedent of f Yes, specify C 1 ☐ Yes 2 🔯 N			Rican, etc.)		Black, Whit	White
ş	2 hou		15. Decedent			16a. Deced	dent's Usual Oc kind of work do	cupation	ant of work	20	16b. l	Kind of Business	/Industry
213-0030	thin 7;	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4or	5+)	ine. L	DO NOT use re	ired)	OSI OI WOIKI	ng			
V	ygien ygien rth rt, the	S	and the second s	5 +		Phys	sician	19 Mo	ther's Name	(First, Middle		ospital	
Maryland		Be	17. Father's Name (First, Middle, I Gordon McPhee	Last)						Senulis		n ourraine)	
Ž	should and Men	ပ္	19a. Informant's Name/Relationsh	tip (Type, Print)		19b. Mailir	ng Address (Stre					or Town, State,	Zip Code)
<u> </u>	and 2 s eaith an n 27 is ner trau		Kathryn H. McPh									y, MD 21	
Baltimore,	es 1 a of Hea if item or othe		20a. Method of Disposition  1X Burial 2 Cremation  4 Donation 5 Other (Sp.	3 □Removal from State	CE	ace of Dispo	sition (Name of matory or other edral Co	olace)		-2005	20c. l	ocation - City or ltimore	Town, State
Baltil	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service I		4M010								mily FH Inc. , MD 21043
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that cause only one cause on each	ed the deeth line.	. Do not ent	er the mode of	dying, such	as cardiac o	or respiratory a	rrest,	cc orcy	Approximate Interval Between Onset and Death 34 hours
	/Medical Examiner		resulting in death)	Due to (or a	s a consequ	uence of):							
L		Jer	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Due to (or a	s a consequ	uence of):							
	ificate be executed g physician and as the burial-transit	Examiner	that initiated events	c									
50,	oe execian a		resulting in death) Last	Due to (or a	s a consequ	uence ot):							
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Box	death cert e attending od for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant	2 Fetal	death 3	□Ectopic pregna □ Other (specify					23d. Date of de Month	olivery Day Year
0	that the	Phy	Part II. Other significant condition	ons contributing to death	but not resu	ulting in the u	nderlying cause	given in Pa	ırt I.	23e. Did	tobacco	use contribute t	o the cause of death?
rds,	w requires that the di been signed by the should be detached	ed by								10	Yes	2 <b>∏</b> No 3 □ P	robably 4 Unknown
Division of Vital Records,	e la has	Completed							<del></del>	24a. Was auto perfe	psy ormed?	prior to death?	utopsy findings available completion of cause of
ta		60	25. Was case referred to medical					26. PI	ace of Deat	h (Check only			
<u> </u>	y s	To B	examiner? 1 Tes 2 No	Hospital: 1 ☑ Inpai	tient 2 🗆	ER/Outpatie	IN SEL DOM				-	6 □Other (Spe	ecify)
o uoi		atlon;	27. Manner of Death  1 XNatural 5 Pendin 2 Accident Investig	ation	jury Jay Year)	28b. Time o Injury		njury at Work? 1 □ Yes 2		28d. Describe	how inj	ury occurred	
Divis	al or Attending safter death. It Director: After do in by the funer	Certification;	3 Suicide 6 Could a determined to the determined of the determined	inad 286. Flace of I	njury - At ho etc. <i>(Specif</i> )	ome, farm, st	reet, factory, off	ice		28f. Location ( City or To			lural Route Number,
	e Hospital or 124 hours afte Funeral Dir letely filled in I	Medical (	29a. Certifier 1 Certifyir (Check only one) 2 Medical	g Physician: To the bes Examiner: On the basis and manner:	of examina	wledge, deat tion and/or in	th occurred at the	e time, date ny opinion, i	and place, death occur	and due to the red at the time,	cause date a	(s) and manner a nd place, and du	is stated. e to the cause(s)
	vithin 2 To the I	Me	29b. Signature and title of certifie	****			29c. Lic	ense numb	er			ate signed (Mon	
)			Ara Sar		>			7701			Ma	ay 17, 2	005
			30. Name and address of person	who completed cause of South Green	death (Item	n 23a) (Type, reet R	Print)	e. MD	21201				
			And Sancrez MD 22  31. Date filed (Month, Day, Year)		strar's Signa			٠, ١٠٠					
	St Regist	ate	MAY 1 S	100		K A	and a						

DHMH 17 Rev 1/2001

ORIGINAL

JET 05-03387 Cordero David Miller

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State	of	Maryland	1/	Dep	artme	nt of	Healt	h and	Mental	Hygiene
				-						

	/Medic Examin Funeral Director
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or Items 23a or 28a-1 show any injury og-

1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 16 2005 CORDERO DAVID May 0905 MILLER al 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital STU Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept. 3,1986 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**⊠** M 2□ F 577-13-8643 Yrs. Wash. 18 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Yes 2□No MD Germantown Montgomery Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19406 Zinnia Circle 20876 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify: Specify: Black Ճ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Student 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William C. Smith Roseita Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roseita Miller (Mother) 19406 Zinnia Circle, Germantown, MD 20876 20b. Place of Disposition (Name of cemeter), crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
'4 ☐ Donation 5 ☐ Other (Specify) Gatte of Heaven Cem 5/21/05 Silver Spring, MD 2. Name and Address of Facility SNCWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service Lîcersee 46 N. Wash. St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. eter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pirysician WOUNDS SHOT GUN KEAD /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗷 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes Division of Vital 2 □ No Attending Physician: 25. Was case referred to medical examiner?
1 X Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 ☑ npatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Natural SUBJECT WAS SYLOT 1 ☐ Yes 2 🗖 No 5/15/05 1:00 A M 2 Accident I Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di SVTSIDE 19406 ZINNIA CRIGERMANTOWN' 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2X Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME the sun May 16 2005

State

Registrar

31. Date filed (Month, Day, Year)

MAY 1 8 2005

MVA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Baltimore, Maryland 21201

			State of Maryland / I				ental Hygie	ene	
	0.		Registrar  1. Decedent's Name (First, Middle, Last)	Cen	ificate of D	reatn	2. Date of Death	J. No. 115	3. Time of Death
	Physicia /Medic		Charles Edward Mills Sr.				May	aa aoos	9:10 AM
	Examin		4a. Facility Name (If not institution, give street and number) Washington County Hospital		4b. City, Town, or L	stown,	•	4c. County of Death Washing	ton
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bit	oirthday)_	If Under 1 Year	•	8. Date of Birth		lena (Ctata as Fassina
L	Director		219-14-8303 <sup>1</sup> X M 2□F 81	Yrs.	Months Days	Hours Min.	8. Date of Birth Month, Day, Y Aug 25	(ear) 923 MD	ntry)
	/land	}	10a. State 10b. County 10c. City, Tow					1	0d. Inside City Limits
	Ba-fst	ctor	MD Washington Big	P00.	<u> </u>	· · ·			1 ☐ Yes 2 ☐ <b>X</b> No
	filed within 72 hours after death with the Maryland Hygiene. wher than "netural", or Items 23a or 28a-f show who, the Madical Examiner out be notified at	Funeral Director	10e. Street and Number 9538 Little Galilee Rd		10f. Zip Code 2171	11	100	p. Citizen of What Cour	itry?
	death	nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of Hisp Yes, specify Cuban,	panic Origin? (Spe	city Yes or No-	14. Race - Americ Black, White,	
20	rs after	by Fu	1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 1 □ Wes 2 □ No If Yes, Give WWII			Specify:	noun, oto.,	Specify: Whi	
	72 hou		15 Decedent's Education 16a	a. Decede	nt's Usual Occupati	ion	16	ib. Kind of Business/In	
7	within ane. Ithan "r	Completed	Elementary/Secondary (0-12) 12th grade Cr	raft	ind of work done du O NOT use retired) Sman/maj	intenna:	nce	State Par	'K
7	illed Hygie other	0	17. Father's Name (First, Middle, Last)			18. Mother's Name			
Z Z	should be and Mental a marked o umatic eve	To B	Garrett C.Mills					h Swandol	
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or Items 23a or 28a-f show any njury or other treumatic event, the Madical Examiner must be multipled at once.							City or Town, State, Zip  9 Pool, MD	
G.	es 1 ar of Hea of Hea fitem ?		cemete	ery, crema	tion (Name of atory or other place)	May 2		c. Location - City or To	
allillo	t. Pag ntment ntent: I		14 Donation 5 Other (Specify)  21. Signatura Sayuneral S		Cemetei		,5	Big Pool,	
0	Department of the policy of th		21. Signaturación sin de la company de la co	DO	nald Edv	vin Thor	npson F	uneral Ho	me
			23a. Part1 Inter the disease, or complications that caused the death. Do ship, or heart failure. List only one cause on each line.						Approximate Interval Betweeni
	Physician /Medical-		Immerate Cause (Final dise e or condition resulting in death)	Q Y	ria				Onset and Death
	Examiner		Due to (or as a consequence	a of):	struct	100 D	ulmen	and direc	ine Thor
	sit s	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	∋ ot):	at the Milateria		MOTH WITH	1	J. W.
'n	execut n and ial-tran	Examine	that initiated events c. Due to (or as a consequence	e of):					
	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	icai	d						
ŏ X O	certific iding p	/Mec	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				7/10/2	23d. Date of delive	
0	death	hysician/Med	in the past 12 months?  1 Yes 2 No  1 Yes 2 No		ctopic pregnancy Other (specify)			Month	Day Year
7.	that the	Δ.	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting it	in the upr	ferlying cause given	in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
cords,	w requires that the death certifics been signed by the attending pt should be detached for use as t	ed by	lung conce	1	- (	2 years	1 X es		ably 4 Unknown
222	e law rei has bee je 2 sho	Completed	Anemia		6	months	24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
E	Th ate pag		- tachy arrythmias			arears C		death?	2□ No
VIIGH	Physicien: r this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes No Hospital: Unpatient 2 ☐ EP/O	Outpatient	3 DOA Other:	26. <del>Plac</del> e of Death 4 ☐ Nursing Hon		pe 6 ☐ Other (Specify	v)
5	fre	ion; T	1 Natural 5 ☐ Pending (Month, Day Year)	Time of Injury	28c. Injury a Work?	at 2	8d. Describe how		
VISION	Attending r death. ector: After by the fune	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa	farm, stree		es 2 No		et and Number or Rura	l Route Number,
5	itel or rs afte ral Dire	O	building, etc. (Specify)			4	City or Town, S		
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	dical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge (Check only one)  Medical Examiner: On the basis of examination are and manner stated.	ge, death o and/or inve	occurred at the time estigation, in my opin	, date and place, a nion, death occurre	nd due to the cau: d at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	1 12	29c. License r	number	29d	. Date signed (Month,	Day, Year)
			Itud Hamo	Sie	L	D464'	13	May.	22,2005
2 2	26		30. Name and address of person who completed cause of death (Item 23a)	113	DPAI	CT.	Hado	ratoun.	nD 21740
• • • • • • • • • • • • • • • • • • • •	Sta Registr	_	34. Date filed (Month, Day, Year)  32. Begistrar's Signature	1.	A.		111	1179411	
	. negisti	वा	MAI 2 4 (1113)   / Maran 2 / 170	1100	ACC.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Deat 1. Decedent's Name (First, Middle, Last) Month Year 150 ? **Physician** Kerby Louise Mumma /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 M 2 X F 521-38-1974 74 **Director** 10/04/1930 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28e-fehov other treumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MDWashington Hagerstown Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 13215 Hillandale Road 21742 US items 23e Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ont: If item 27 Is merked other then "naturel", or Items 23 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Occupational Therapist Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louise Maria Turner Leo William Butler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Importent: If item 27 is any injury or other tre-Christine L. Burkhardt/Daughter 3133 Connecticut Ave., NW, Washington, DC 20008 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Rest Haven Cemetery 05/20/2005 Hagerstown, MD \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Sign June of Funeral Service Licenses Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each time Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician O Card minutes /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Be Completed by Physician/Medical Examiner the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, use as f IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 No Hospitel or Attending Physicien: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 区ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No М after death 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of

JH-20

State Registrar

DHMH 17 Rev 1/2001

ted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

			State of Maryland / Depa	artment of Health and Mattificate of Death	lental Hygie	•	18559
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Media	cal	Helen Elizabeth Mordoff		May 13		0041 M
	Examir	er	4a. Facility Name (If not institution, give street and number) 17921 Marshall Mill Road	4b. City, Town, or Location of Death Hampstead		4c. County of Death Baltimo	re
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, ) Jul 24,	Year) 9. Birthp Coun 1919 Penn	lace (State or Foreign try) sylvania
	land		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Loc	cation		11	Od. Inside City Limits
	Mary B-f sh	tor	Maryland Baltimore	Hampstea	nd		1 □ Yes 2√∑ No
	th with the 23a or 28a	al Director	10e. Street and Number 17921 Marshall Mill Road	10f. Zip Code 21074	100	g. Citizen of What Coun	try?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Exertiner roust be nutified at Once.	by Funeral	If Yes, Give 1  3X Widowed 4 □ Divorced Year or Dates:	Vas Decedent of Hispanic Origin? (Spr I Yes, specify Cuban, Mexican, Puerto □ Yes 2√□ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, of Specify:	
1215-0	vithin 72 ho ne. han natui e Nedical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  Coilege (1-4or 5+)	lent's Usual Occupation kind of work done during most of worki DO NOT use retired) HOmemaker	ing 16	Own Home	lustry
Maryland 21215-0036	ild be filed w lental Hygiei kad othar ti ic evant, In	To Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma Le Ardis		
	and 2 shou alth and M 127 Is mai		19a. Informant's Name/Relationship ( <i>Type, Print</i> ) 19b. Mailin	g Address (Street and Number or Rurall Marshall Mill Ro	and Hamp	ot-ond MD	21074
Baltimore,	Pages 1 annent of He ant: If itam ary or othe		20a. Method of Disposition 1   Burial 2 □ Cremation 3   Removal from State  '4 □ Donation 5 □ Other (Specify)  20b. Place of Disposicementary, crem  Glen Rest	sition (Name of natory or other place)  Memorial  Name and Address of Facility	2005 Re	oc. Location - City or To eynoldsburg	wn, State , Ohio
Balt	permit. Departr Imports any inji		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Name and Address of Facility  934 South Main St	TITLE I U	iciai none	
	enysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on such line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	r the mode of dying, such as cardiac of		chon	Approximate Interval Between Onset and Death
	Examiner	Jer	Sequentially list conditions	ò	U		_
760,	ificate be executed g physician and as the burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of):				
.O. Box 68	death cert e attending d for use a	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2 Vino   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   4   Pregnant at time of death   5   9   Unknown   5	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year
rds, P	The law requires that the tite has been signed by the bage 2 should be detache	by	Part II. Other significant conditions continuously to death but not resulting in the dif	derlying cause given in Part I.	23e. Did toba	cco use contribute to th	e cause of death?
al Record		Completed			24a. Was an autopsy performe	prior to con	sy findings available apletion of cause of
Vital	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1  Yes 2 Mo  Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death  Other: 4 Nursing Hor	1	ce 6 □Other (Specify	
Division of	Jing After fune	tlon: T	27. Manner of Death  1 Satural 5 Pending (Month, Day Year)  2 Accident investigation		28d. Describe how		
Divis	- 9 - 7	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, streed building, etc. (Specify)	et, factory, office	28f. Location (Stree City or Town, 1	et and Number or Rural State)	Route Number,
	To the Hospital or within 24 hours after to the Funeral Dir completely filled in	edical	29a. Certifier (Check only one)  1	occurred at the time, date and place, a estigation, in my opinion, death occurr	and due to the caused at the time, date	se(s) and manner as sta a and place, and due to	ated. the cause(s)
	/	Σ	29b. Signature and title of certifications and title of certifications and title of certifications are considered as a second certification of the certifica	29c. License number	29d	. Date signed (Month, L	Day, Year)
•	A		30. Name and address of person who completed cause of death (Them 23a) (Type, F	D42410	) 5	112/02	
	12		12221 TULL AMORE CO	IMONIUM, V	ND Z	1093	
•	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 6 2005  32. Begistrar's Signature	arki .			

		1 - For State Registrar	State of M	aryland / Dep	artment of He rtificate of D	alth and M	lental Hygi	iene g. No.		1856	in
Physici	an	Decedent's Name (First, Middle,					2. Date of Death Month May	Day 200	Year	3. Time of De	
/Medi			on Meade Ni	ckle			May .			2225	М
Examir	er	4a. Facility Name (If not institution,		N 4	4b. City, Town, or L			4c. County of		-	
Funeral		Calvert Manor F  5. Social Security Number		enter  e (In yrs. last birthday)		ng Sun If Under 24 Hrs.	8. Date of Birth	<u> </u>	Ceci 9 Birthola		oreign
Funeral Director		214-20-1587 Usual Residence of Decedent	1፟፟፟M 2□F	79 Yrs.	Months Days	Hours Min.	(Month, Day, July 17	Year) , 1925	Countr	ce (State or Fo y) yland	g
yland 10W		10a. State 10b. County		10c. City, Town or Le	ocation				100	d. Inside City L	imits
e-fsl	tor	Maryland C	ecil		Perry	ville				1 ☐ Yes 2🖔	οMΩ
ith th	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	hat Countr	y?	
ath w 239	'a	510 Jackson Sta				.903			5.A.		
S should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked othar than "netural", or Itams 23e or 28e-f show aumatic evant, the Moderal Examiner must be notified a	by Funerai	11. Marital Status  1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces?  1 XYes 2 If Yes, Give Year or Dates:	No	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ☑ No		ecify Yes or No- Rican, etc.)	14. Race Black Specify:	- America , White, et Wh	n Indian. tc. nite	
72 ho	ted	15. Decedent's		16a. Dece	dent's Usual Occupati	on	1	6b. Kind of Bus	iness/Indu	ıstry	
thin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+) (GIVE	dent's Usual Occupati a kind of work done du DO NOT use retired)	ring most of worki	ng A	berdeen	Prov	ing Gr	our
id 2 should be filed within 72 hours aft th and Mental Hygiene. 77 is marked othar than "netural", or traumatic evant, the Modical Exami	5	Nine Years			Mechanic			berdeen		yland	
be fill tal Hy d oth	Be	17. Father's Name (First, Middle, L.			1	8. Mother's Name	,		)		
should nd Men marke umatic	မ		cis Clyde N				Bessie				
permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic <u>once</u> .		19a. Informant's Name/Relationshi Grace Farmer Nie			ng Address (Street an					,	
1 and Health em 27 ther tr		20a. Method of Disposition	okie (wile	- 1	Jackson Sta			yville,			190
Pages nent of P ant: If ite ury or of		1 ☑ Burial 2 ☐ Cremation			osition (Name of matory or other place)	1					
it. Partumer rtant njury		<ul> <li>4 □ Donation 5 □ Other (Special Signalure of Funeral Service Lieuway)</li> </ul>		-	Cemetery	05/2		ort Dep			and
permit. Departr Imports any inje		Thomas M.	THEREM	P.	2. Name and Address ee A. Patt erryville,	Marylan	d 2190	3-0766	е, Р.	Α.	
Pnysician /Medical		23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	a	ne.	ter the mode of dying,		r respiratory arre	st,	1	Approximate nterval Between Donset and Deat	n th
cate be executed was physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated events resulting in death) Last	c	a consequence of):							
at the death certificat by the attending phy stached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mont		, Jay Year	,
w requires that s been signed b should be deta		Part II. Other significant condition	1		inderlying cause given	in Part I.	23e. Did toba	acco use contrib		cause of death	
Phyaician: The law requires that the this certificate has been signed by the director, page 2 should be detache	Completed	Hyperlipiden	. )				24a. Was an autopsy perform 1 Yes 2-	ed? pri	ere autops or to comp ath? ] Yes 2	y findings avail pletion of cause	lable e of
	Bec	25. Was case referred to medical			2	26. Place of Death					
	ပို	examiner?  1 Yes 2 No  27. Manner of Death Natural 5 Pending 2 Accident investiga	28a. Date of Inju (Month, Da		f 28c. Injury a Work?	4 A Nursing Hon	ne 5 Resider 28d. Describe how				
To the Hospital or Attending within 24 hours after death.  To tha Funaral Diractor: After completely filled in by the funer	Certification:	3 Suicide 6 Could no 4 Homicide determin	t be Diago of Ini	ury - At home, farm, str c. (Specify)	reet, factory, office	2	28f. Location (Stre City or Town,	eet and Number State)	or Rural F	Route Number,	
To the Hospital or within 24 hours afte To tha Funaral Dii completely filled in	edicai (	29a. Certifier 1X Certifying (Check only one) 2 ☐ Medical E	Physician: To the best caminer: On the basis o and manner st	f examination and/or in	h occurred at the time, vestigation, in my opin	date and place, a tion, death occurre	and due to the car ad at the time, dat	use(s) and mani te and place, an	ner as state d due to th	ed. le cause(s)	
To the within To the comp	Me	29b. Signature and title of certifler	le mo		29c. License n	2050		d. Date signed	05	y, Year)	
3+VA		30. Name and address of person w	no completed cause of d	leath (Item 23a) (Type, i 5 S , Pa	rint) Ace St. #	too Abe	rdeen M	0 2100	>		
Sta Registr	-	31. Date filed (Month, Day, Year) MAY 1 8 2005	32. Registr	ar's Signature	,						

			1 _ State	of Maryland /		rtment of Hotificate of L			31.00	000	
			Registrar  1. Decedent's Name (First, Middle, Last)			incate of L	Calli	2. Date of Dea	th	U U 5-	3. Time of Death
и	Physici /Medic		RUTE	EUGENIA	OH	LER		MAY 15	Day 2.1	Year 0 0 5	12:15A <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and nu	imber)		4b. City, Town, or	Location of Death		-	ounty of Death	
			LORIEN NURSING CENT			TANEY				ARROLI	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 M F	7. Age (In yrs. last b	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	, Year)	9. Birth	place (State or Foreign intry)
			Usual Residence of Decedent	07				2/27/	1918	MAR	YLAND
	nylan show		10a. State 10b. County	10c. City, To	wn or Loc	eation					10d. Inside City Limits
	8a-1 s	Director	MD CARROLL	WES	STMI	NSTER					1 ☑ Yes 2 ☐ No
	with the		10e. Street and Number 49 S. CHURCH ST.			10f. Zip Code	7		-	n of What Cou	intry?
	ns 23	Funeral	11. Marital Status 12. Was Dec	edent Ever in U.S.	13. V	21157 Vas Decedent of His		ecify Yes or No-	USZ	Race - Amer	can Indian.
9	or Itar	Fun	Armed F 1X Never Married 2  Married 1	orces? 2 🕅 No	J1	Yes, specify Cubar	, Mexican, Puerto	Rican, etc.)		Black, White	
99	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Itams 23e or 28e-f show ent, the Medical Exant act matter indified at	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, G Year or [	Dates:	'	☐ Yes 21X No	Specify:		Sį	pecify: WH	ITE
21215-0036	"natu	Completed	<ol> <li>Decedent's Education (Specify only highest grade completed)</li> </ol>	166	(Give I	ent's Usual Occupa kind of work done do OO NOT use retired)	uring most of wor	king		of Business/Ir	ndustry ESERVE
7	within iene.	ашо	Elementary/Secondary (0-12) College (	1-4or 5+)		URITIES			BANK		BBERVE
	e filled I Hyg othar	Φ	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Su	ітате)	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Itam 27 is marked other than "natural", or Itams 23e or 28a-f show other traumatic event, it is Medical Exanta at must be rediffied at	To B	A. MEADE OH	LER			SARAH	PAULI	NE F	RIZZE	LL
Jar	2 sho					g Address (Street a			-	P	RATITIMORE
	1 and 2 Health am 27 thar tra		MARTIN A. CONOVER -	NEPHEW 1		W . UNIVE		PARKWAY Date		IT 2,	D. 21210
nor			1X Burial 2 ☐ Cremation 3 ☐ Removal from  4 ☐ Donation 5 ☐ Other (Specify)	State cemete	ery, crem	ratory or other place	) !	8/05			ER, MD.
altimore,	permit. Page Department of Important: If any injury or once.		21. gnatur V Seral Service Licensee	1		Name and Address		· ·			
ä	Per		VA			4 E. MAI					
I			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do	not ente	r the mode of dying	, such as cardiac	or respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease) or condition	URCHER	sis						1 week
	/Medical Examiner		resulting in death)  Due to	(or as a consequence	of):						
١,	_	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	(or as a consequence	of):						
	be executed sician and burial-transit	Examiner	that initiated events								
Ó,	cate be executed obysician and the burial-transit			(or as a consequence	of):						
8760,	ate hy:	dlcal	d.						_		
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Ö.	t the c by the achec	hysi	9 Unknown 9 Unkn				W 10 1				
S, D	res that the de signed by the a be detached f	by P	Part II. Other significant conditions contributing to d		in the un	derlying cause giver	ı in Part I.	23e. Did tol	oacco use	contribute to t	he cause of death?
ord	w require been signature	ted	Luxenstrem	(A				1 🗆 Yı	s 2 🗐	√o 3 □ Prot	pabły 4 □Unknown
Records,	2 8 2	ompleted	Demo entron					24a. Was a	У	4b. Were auto	opsy findings available impletion of cause of
		0	Whener,	Dement	2 ــــــــــــــــــــــــــــــــــــ			perform 1 Tes		death? 1 ☐ Yes	2 🗆 No
Vital	Physician: r this certific ral director.	o Be	25. Was case referred to medical examiner?  1 \( \sum \) Yes 2 \( \sum \) No Hospital:	Inpatient 2 ☐ ER/O			26. Place of Deat			701 (0	
0	ding Physi h. After this c funeral dir	-	27. Mannar of Death 28a. Date	of Injury 28b.	Time of	3 ☐ DOA 28c. Injury : Wark?	4 Nursing Ho	28d. Describe ho			у)
joi	andin eath. or: Aft	atlo	2 Accident investigation	th, Day Year)	Injury		9s 2 □ No				
Division	afor Attand after death Diractor: /	Certification:	3 Suicide 6 Could not be determined 28e. Place build	e of Injury - At home, f ing, etc. <i>(Specify)</i>	arm, stre	et, factory, office		28f. Location (St City or Town		lumber or Rura	al Route Number,
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer		29a. Certifier 1 Certifying Physicien: To the	hast of my knowled-	an done-	ongurred et 25 - 45	data and dis-	ned done to the		d	
	a Hos 24 hc a Fun letely	edical	(Check only 2 Medical Examiner: On the b	a best of my knowledg asis of examination al ner stated.	nd/or inve	estigation, in my opi	nion, death occur	and due to the cared at the time, d	use(s) and ate and pla	a manner as s ace, and due to	iated. o the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	1000		29c. License	number	2	9d. Date s	igned (Month,	Day, Year)
)	M.		) ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~			~	7 436	43	5	~15-	65
1	MJG		30. Name and address of person who completed cause				r . T2	neutou			21787
	1		31. Date filed (Month, Day, Year) 32. F	Registrar's Signature		rings D	12	neutou	w,	1400	- · · · · · · · ·
	Sta Registr	-	MAY 1 7 2005		× 4	hadis					

			1 For State	State of Maryland /			lental Hygier	ne	
			Registrar		Certificate of	Death	Reg. I	40. 200	5 1000
	Physici		1. Decedent's Name (First, Middle, L.	Perkins				Day Year	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, gi		4b. City, Town, o	or Location of Death		4c. County of Deat	22 (O PM
	LAGITIII		0 1 11	Pice AT the L	eke Sal	lis bur	-4	1 1.	omico
-	Funeral		5. Social Security Number 6.	Sex 1	Months Days	If Under 24 Hrs. Hours Min.	8 Date of Birth (Month, Day, Yea	9. Birt	hplace (State or Foreign
	Director		Usual Residence of Decedent	16	Yrs.		May 11, 19		laware
	/land		10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits
	Many Ba-f sh	tor	Deliunie Suss	ex Spr.	ora				1 Yes 2 □ No
	if the	Directo	10e. Street and Number	-1	10f. Zip Code		10g. (	Citizen of What Co	untry?
	eth w		747 Purnell	St		973	Uni	ted State	
	ter de	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto I	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
920	hours after deeth with the Maryland turel, or ttems 23s or 28s-f show all Exartic sermant be notified at	by	3 Widowed 4 Divorced	1  Yes 2 No If Yes, Give No Year or Dates:	1 ☐ Yes 2 No	Specify:		Specify: B	lack
21215-0036	d within 72 hours after deeth with the Marylan liene. r than "naturel", or items 23s or 28s-f show the Medical Exercites Remosite or notified at	Completed	15. Decedent's E (Specify only highest gi	Education 16	Sa. Decedent's Usual Occup (Give kind of work done)	ation	16b.	Kind of Business/	Industry
21	within iene.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired	d)			
2	filled v Hygia ther t		17. Father's Name (First, Middle, Las	<u>,                                    </u>	leather		(First, Middle, Maide	location	)
Maryland	e d al e	To Be	0 1 0 0 3	ain Perkins		Margar	1 .		Prinell
ary	ges 1 and 2 should t of Heelth and Men If item 27 Is marke or other treumatic	-	19a. Informant's Name/Relationship	(Type, Print),	9b. Mailing Address (Street	and Number or Rura			Zip Code)
	and 2 seith a n 27 i		Mia Hooper/D		147 Purnell St	t, Seaford	DE 19	973	
Baltimore,	Pages 1 nent of He int: If iter		20a. Method of Disposition  1 Burial 2 Cremation 3 [	□Removal from State ceme	of Disposition (Name of tery, crematory or other place	ce)	-	Location - City or	Town, State
ij	t. Pa rtmen rtent: rjury		`4 ☐ Donation   5 ☐ Other (Speci	Mace Mace	donk ANE Com	1 10021 ~	1,2005	interd J	25
Ba	permi Depa Impo eny is		21. Signature of Funeral Sovice Lice	ensee Dinnie A Main	11	ss of Facility	369	North 3	
			23a. Part1. Enter the disease, or con shock, or hear Hillure. List only	nplications that caused the death. D	o not enter the mode of dyin	ICTUL HOME	r respiratory arrest.	rd DE	19963 Approximate
	Physician		Immediate Cause (Final	one cause on each line.	CIRRHO	,	, , , , , , , , , , , , , , , , , , , ,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a consequenc	e of):	3/3			1 YEAR
	Examiner	L	Sequentially list conditions,	0.	1 TIS - C				YRARS
	pe isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequenc	e of):				
	al-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequenc	e of):				
8760,	icate be executed physicien and s the burial-transit		(	d					
9	ntifica ng ph	Physician/Medical	IF FEMALE:						
Вох	death certific e attending p d for use as i	ian/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea		1		23d. Date of deli-	
P.O.		ysic	1 ☐ Yes 2 ☐No 9 ☐ Unknown	4□Pregnant at time of death 9□ Unknown	5 Other (specify)			WORTH	Day Year
	that the photograph of details		Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause give	en in Part I.	23e. Did tobacco	use contribute to	the cause of death?
rds	The law requires that the the has been signed by thoage 2 should be detache	ed by					1 ☐ Yes	2 <b>X</b> No 3 □ Pro	obably 4 Unknown
000	e law re has bee	plet					24a. Was an	24b. Were aut	opsy findings available ompletion of cause of
<u> </u>		Completed					autopsy performed?	death?	2 No
Vita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		26. Place of Death			
Division of Vital Records,	Attending Physicien: r death. sector: After this certific by the funeral director.	2	1 ☐ Yes 2 No  27. Manner of Death		Outpatient 3 DOA Other	4 Li Nursing Hom	ne 5 Residence	6 Other (Spec	ity) HOSPICE
on	th. : Afte	tlon	1 XNatural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year)	Injury Work	k? Yes 2 □ No	od. Describe flow inj	lly occurred	
Visi	Attendi ar death. ector: A by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	2	8f. Location (Street a	and Number or Rui	ral Route Number,
٥	itel or A	Cer				7	City or Town, Sta		
	s Hospitel or 24 hours afte b Funerel Dir etely filled in I	edical	(Oneck only Z Medical Exe	hysicien: To the best of my knowledgeminer: On the basis of examination a	ge, death occurred at the tim and/or investigation, in my op	ne, date and place, ar	nd due to the cause( d at the time, date ar	s) and manner as	stated.
	To the Hospitel or Attending Physicien: which 24 hours after deals. To the Funerel Director: After this certific completely filled in by the funeral director.	Med	one) 29b. Signature and title of certifier	and manner stated.					
)	F 3 F ŏ		Il on	3-1110	Non R	24/13	250.0	1/17/00	/
	3		30. Name and address of person who	completed cause of death (Item 23a) R (\$\sum_{\cute{\c	) (Type, Print)			1.1103	
	12		GHULAM WAS	PLS 26266	ARROWNOOL	O CT.	SALISBU	1124 m	0.21801
ş.	Sta		31. Date filed (Month, Day, Year) MAY 1 9	2005 32. Redistrar's Signature					
	, ∍ Registr;	સા		- Jacobson St	Coarle				

		_ '	1 - For State Registrar	State of Marylan		artment <i>tificate</i>			d Mer		ene	20	05	1856	S Section
	Physici		Decedent's Name (First, Middle, Last)     Ky	le Perry						Date of Death Month Iay	Day 19	200	ear 05	3. Time of Death 7:00 A <sup>M</sup>	
	/Medic Examir	- 100	4a. Facility Name (If not institution, give s 6513 Belleview Dri			Co	1um1	Location of D	Death		4c. 0	County of t	eath vard		
ľ	Funeral Director		220 24 7908	7. Age (In yrs. i	ast birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hours	Min.	Date of Birth (Month, Day, an 9,	Year) 1928		Count	ace (State or Foreign ry) Nessee	
	e Maryland le-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  MD Howard		y, Town or Lo							10d. Inside City Limit: 1 ☐ Yes 2 🖫 No			
	vith th	Director	10e. Street and Number			10f. Zip C				10		en of Wha		•	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28e-f show empiriquy or other traumatic event, the Medical Examiner must be notified at Once.	by Funeral	6513 Belleview Dri  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	VC  12. Was Decedent Ever in U. Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	'	Was Decede	y Cuba	46 ispanic Origin n, Mexican, P Specify:	n? (Specify Puerto Rica	Yes or No- an, etc.)	1	ited  4. Race - A Black, N Specify:	America	n Indian, tc.	
Maryland 21215-0036	within 72 ho ane. then "natur be Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give life. l		done d retired	ation during most of Derviso		1		d of Busin			
land 2	ild be filed lental Hygie ked other ilc event, III	To Be Co	17. Father's Name (First, Middle, Last) unknown		INOAC	CLEW	Su		Name (F	rst, Middle, M		Sumame)	COL	incy	
Mary	nd 2 shou (lith and M 27 is mar r traumat	-	19a. Informant's Name/Relationship (Type Coleen J. Rodberg/)							oute Number, MD 2	-		te, Zip	Code)	
Baltimore,	Pages 1 arener of Hearnt: If item		20a. Method of Disposition  \$ Burial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)	20b. P emoval from State	lace of Dispo emetery, cren umbia	sition (Name natory or oth	e of ner plac	θ)	Date -21-2	2	Oc. Loc	ation - Cit ksvi			_
Balti	permit. Departrimports eny inju		21. Signature of Funeral Service License	- attle	044 22 41	Name and	Addres	s of Facility	Harr	y H. W	itzk	œ's	Fami	.ly FH Inc 1D 21043	:.
2.00	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.  REPINATO  Due to (or as a consequence)	RRY	ARM	of dying	g, such as car	rdiac or re	spiratory arre	st,			Approximate Interval Between Onset and Death	
8760,	icate be executed physician and sthe burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to	uence of):										
.O. Box 68	death certif e attending ed for use a	by Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	Ectopic preg Other (spec					23	3d. Date of Month		y Day Year	
٩	Se De G	d by Ph	Part II. Other significant conditions con	tributing to death but not rest	ulting in the u	nderlying cau	use give	en in Part I.		23e. Did toba			te to the	cause of death?	
Division of Vital Records,	The law ate has t page 2 s	Completed							_	24a. Was an autopsy perform 1 Yes 2	,	24b. Wer prior deat 1 🗆	h?	sy findings available pletion of cause of No	
Z.	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	it 3 DOA	Othe	11-11-11-11-11		heck only one 5 ≿ Resider		Other (	Canaik		-
ion of	Attending Phy ir death. ector: After this by the funeral d	H- 4	27. Manner of Death  1 Natural  2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		c. Injury Work	at	28d.	Describe how			эр <del>в</del> спу)		
Divis	Dir.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	eet, factory,	office		28f.	Location (Str. City or Town,		Number o	r Rural	Route Number,	
	he Hospitel or n 24 hours afte he Funeral Dir pletely filled in l	edical	29a. Certifier 1 Certifying Phys (Check only one) 1 Medical Examin	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at vestigation, in	t the tim in my op	ne, date and p pinion, death o	olace, and occurred a	due to the car it the time, da	use(s) a te and p	nd manne place, and	r as sta due to	ted. he cause(s)	
)	To the within 2: To the I	Σ	29b. Signature and title of certifier	us M.I)	,			720	5			signed (N			
			30. Name and address of person who con	ROAD #10, C	o Lum!	Print)	MI	)-210	45.	DR.	. N	IRA	ATW	5 N. N. Jan	I
	Sta Regist		31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture	and a									

		State of Maryland / Department of Health and Mental Hygiene 2 0 5 18561  Certificate of Death Reg. No.
Physicia /Medic	al	1. Decedent's Name (First, Middle, Last)  Edna Matilda Parrish  4a. Facility Name (If not institution, give street and number)  2. Date of Death Month Day Year 2330 M  4b. City, Town, or Location of Death 4c. County of Death
Examino Funeral Director	GI.	Caroll Unspital (ofter Caroll Control Caroll
death with the Maryland sms 23e or 28a-f show	Funeral Director	Usual Residence of Decedent  10a. State
init. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artiment of Heatth and Mental Hygiene. artiment of Heatth and Mental Hygiene. artiment: If time 27 is marked other then "neturel; or items 23e or 28a-f show injury or other treumatic event, the Medical Examinar must be notified at injury or other treumatic event, the Medical Examinar must be notified at injury or other treumatic event, the Medical Examinar must be notified at injury or other treumatic event, the Medical Examinar must be notified at injury or other treumatic event, the Medical Examinar must be notified at injury or other treumatic event, the Medical Examinar must be notified at injury or other treumatic event, the Medical Examinar must be notified at injury or other treumatic event, the Medical Examinar must be notified at injury or other treumatic event, the Medical Examinar must be not the examinar must be not	Completed by	1 Never Married 2 Married 3 Married 3 Married 3 Married 3 Married 4 New Par or Dates:   1 Yes 2 No Specify:   Specify:   Specify:   White
s 1 and 2 should be of Health and Mental item 27 is marked other treumatic even	To Be	Joseph Smith  19a. Informant's Name/Relationship (Type, Print)  Thomas H. Parrish - son  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  1685 Exeter Rd., Westminster, MD 21157  20a. Method of Disposition  20b. Place of Disposition (Name of completely crematory of other place)  20c. Location - City or Town, State
permit. Pages Department of Importent: If its any injury or o once.		Winters Cemetery May 14,2005 New Windsor, MD  21. Signal of Funeral Service Licensee Affords State  22. Name and Address of Facility Hartzler Funeral Home 310 Church St. New Windsor, MD 21776
Physician /Medical Examiner  he privativansit	Ilcal Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):
ti the death certifica by the attending ph tached for use as th	Physician/Med	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1
The taw requires that has been signed page 2 should be de	Completed by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1
Lor Attending Physicien: The alter death.  Jine the thin sentificate in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner?  1   Yes 2   Yes    1   Yes 2   Yes    1   Yes 2   Yes    28a. Date of Injury    (Month, Day Year)  28b. Time of Injury    (Month, Day Year)  28b. Time of Injury    (Month, Day Year)  28c. Injury at Work?    1   Yes 2   No  28d. Describe how injury occurred  28d. Location (Street and Number or Rural Route Number, City or Town, State)
Ihe Hospite iin 24 hours the Funerel	Medical Ce	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
OE'S		30. Name and address of p son who completed cause of death (Item 23a) (Type, Print)  1. VII. 4. 4. 2. 245 Stands Ac 4. 327 (1)25t who steel MD 21(57)
Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 6 2005  32. Registar's Signature

			For State Registrar	State of Maryland		rtment of H		_	giene Reg. No. 2	005	18565
	Physici		1. Decedent's Name (First, Middle) Last	Prinos				2. Date of De. Month	Day	Year	3. Time of Death
	/Medic Examin	er	4a f-acility Name (If not institution, give	eat the	ake	4b. City, Toyrn, or	Location of Death	U Ma	1 1	punty of Death	milla
	Funeral Director		219-01-7786	7. Age (In yrs. Ia	Yrs.	Months Days	Hours Min	8 Date of Bin (Month, Da August	25,19	9. Birthpi Count Mar	ace (State or Foreign ry) ryland
	yland now		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	ation	-			10	od. Inside City Limits
	Ra-f s	Funeral Director	MD Wicomico	Sa.	lisbur				10- 6%		1 <b>∑</b> Yes 2 □ No
	with t	ă	10e. Street and Number 819 Riverside Road	9		10f. Zip Code 21801			USA	n of What Count	ry?
	death ms 2;	nera	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. V	_L	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No		Race - America	
9800	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "neturel", or Items 23e or 28e-f show or other treumetic event, if a Macfiel Examinational treumetic event, if a Macfiel Examinational treumetic event.	by	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 ☐ Yes, Give Year or Dates:		Yes 2 No	Specify:	o Rican, etc.)	!	Black, White, e	
21215-0036	within 72 h ene. than "netu	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Give I	ent's Usual Occup kind of work done o OO NOT use retired	during most of won	king	16b. Kind	of Business/Ind	ustry
21	e filed wit al Hygiene other the vent, II e	Con	12		Seam	stress	40.14.4.1	(F) 1414		facturin	ng
Maryland	ould be fil Mental H arked ott etic even	To Be	17. Father's Name (First, Middle, Last)  Robert Bozman				18. Mother's Nam Annie W		Maiden Su	imame)	
lary	2 should be and Mental Is marked reumetic ev	-	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailin	g Address (Street	and Number or Ru	rai Route Numbe	er, City or T	own, State, Zip	Code)
Baltimore, M	es 1 and 3 of Health fitem 27 r other tr		Robin Washburn/Da 20a. Method of Disposition 1 Aburial 2 Cremation 3 Di	20b. PI	ace of Dispos	iverside sition (Name of natory or other place Memoria)	Rd. Sali	sbury, J	20c. Local	01 tion - City or Tov	wn, State
ţ	permit. Pages Department of Importent: If it any injury or o		`4 ☐ Donation 5 ☐ Other (Specify,	Pai	ck		5/21			oury, Ma	
Bal	Depar Impo any ir		21 Signature of Funeral Service Cens	1/_	H	olloway E	Funeral H Hill Rd.	lome Pro	fession MI	onal Ass	sociation
			23a Part1. Enter the disease, or comp	dications that caused the death	. Do not ente	or the mode of dyin	g, such as cardiac	or respiratory a	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Ceverois	ulen	- Acci	dent				Onset and Death
	/Medical Examiner		resutting in death)	Due to (or as a consequ	ence of):						
	,	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequ	ence of):						
	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequ	ence of):						
8760,	icate be ex physician s the buria		l	d							
9	ntificate ng physi s as the	Medical	IF FEMALE:								
O. Box	the death certific y the attending p ached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 hlo 9 Unknown	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 [	Ectopic pregnancy Other (specify)	,		230	I. Date of deliver Month	y Day Year
σ.	res that the designed by the	by Ph	Part II. Other significant conditions co	entributing to death but not resu	Iting in the ur	derlying cause give	en in Part I.	23e. Did to	obacco use	contribute to the	e cause of death?
ord	v requires that been signed b should be deta							10	es 2	No 3 Proba	ibly 4 □Unknown
Vital Records,	e lav has je 2	Completed						24a. Was autor perfo	SV	24b. Were autop prior to com death? 1 \( \sum \) Yes	sy findings available pletion of cause of
/ita	Physicien: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	Hannital 1		0#	26. Place of Dea	th (Check only e	пе)		,
o	Phys r this ral dii	on: To	1 Yes No  27. Manger of Death Natural 5 Pending	Hospital: 1 Aspatient 2 1 1 28a. Pate of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. injun Worl	y at k?	ome 5 Resident			)
Division	ten leatl tor: the	ertification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	286. Place of Injury - At no	me, farm, stre		Yes 2 □ No			lumber or Rural	Route Number,
ā	itel or A	O		building, etc. (Specify				City or Tov			
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edical		/sician: To the best of my knowiner: On the basis of examinat and manner stated.							
	To th Withir To th comp	Me	29b. Signature and title of certifier,	1. M		29c. Licenso	e number		29d. Date s	igned (Month, D	Day, Year)
)	0\$		JUN S	eff, W		00	7627	8	5	-16-	05
	2 de		30. Name and address of person who o	completed cause of death (Item	)	Print)	BUX 173	33 SA	LISRIE	y aan	05
100	Sta Registr	100	31. Date filed (Month, Day, Year) MAY 1 8 2	32. Paistrar's Signat	b A	perte		J 971	-007	7 1000	

			1 - For State Registrar	State of M	/laryland / I		artmen rtificate				R	eg. No.	005	185	56
	Physici	an	Decedent's Name (First, Middle, La	-							2. Date of Dea Month	1 <sup>Day</sup>	2005	3. Time of Dea	
	/Media	al	Joyce Ann Ric  4a. Facility Name (If not institution, give		(r)		4h Cih	Town or	Location of	of Doath	May	_	unty of Death	10:24 A	. ~
	Examin	er	2423 Kinderbrook		'/			Bowi		JI Deall)			•	orge's	
	Funeral		5. Social Security Number 6. 5	Sex 7. A	Age (In yrs. last bi	rthday)	If Under	1 Year	If Under	24 Hrs. Min.	8. Date of Birth			plece (State or Fo	oreign
	Director		229-30-7013	1□M 2X0F	70	Yrs.	Months	Days	Hours	Min.	Feb. 2,	1935	Vir	ginia	
	and w		Usual Residence of Decedent  10a, State 10b, County		10c. City, Tow	vn or Lo	cation							10d. Inside City L	imits
	Maryli f sho	ō	Md. Prince	Georges	Bowi									1 <b>∑</b> Yes 2[	□No
	r 28a-	Funeral Director	10e. Street and Number				10f. Zip	Code				I0g. Citizer	of What Cou	intry?	
	h with	a D	2423 Kinderbrook	Lane				20	0715			USA			
	ems ems	iner	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S.	13.	Was Deced	dent of Hi	spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	14.	Race - Amer Black, White		
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, it a Marical Examinar must be mailled at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes 2 X	No		1 🗆 Yes					Sp	ecity: Whi		
Ö	hour tural	ed b	15. Decedent's E	Year or Dates		. Dece	dent's Usua	al Occupa	ation				of Business/li		
15	in 72 in "na Marik	Completed	(Specify only highest grant Elementary/Secondary (0-12)			(Give	kind of wo	rk done d se retired	luring mos )	t of work	ing			,	
212	giene grene er tha	E O	12	Oollege (1:40	Н	lome	maker	•				Own h	ome		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan n and Mantal Hygiene. I a marked other than "natural", or flems 23a or 28a-f show raumatic event, II a Madical Examiliter man be traffilled at	Be	17. Father's Name (First, Middle, Last		1 0				18. Mothe		(First, Middle,		•		
<u>Y</u>	ould Men narke	၉		mes Patri			411	(0)	- 1011		onnie C.			- 0. 11	
Mai	D = C =		19a. Informant's Name/Relationship ( Leon E. Rice, Jr								Na Poute Number				
	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		20a. Method of Disposition		20b. Place o	of Dispo	sition (Nan	ne of					ion - City or T		
Baltimore,	permit. Pages Department of I Important: If it any Injury or o once.		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	□Removal from Stat fv)	Metrop	-	natory or o			05-19	9-05 A	1exan	dria,	VA.	
altii	Departm Departm Importar any Injur		21. Signature of Funeral Service Lice		1/	T	2. Name an			by Be	eall Fun				
m	Departi Departi Impo		) (Cu	1000	alf		6512	N.W.	Crai					d 20715	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus one cause on each	ed the death. Do line.	not ent	er the mod	e of dying	g, such as	cardiac (	or respiratory arr	est,		Approximate Interval Betwee Onset and Dear	
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. MX	STASTAT	70	1	un	Cs (	AN	CAR			8 MON	1718
	/Medical Examiner		Tosaking in dodiny	Due to (or a	as a consequence	of):			,						
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or a	as a consequence	of):									
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C											
o,	an an		resulting in death) Last	Due to (or a	as a consequence	of):									
8760,	ate be executed inysician and the burial-transit	lical		d				_							
9	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:	23c. If yes, outcom	a of programov										
Вох	attend for us	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death at time of death		Ectopic pr					23d	. Date of delive Month	rery Day Year	r
P.O.	that the de led by the a detached	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown			20000 (0)	,,							
	res that igned b	by Pi	Part II. Other significant conditions	contributing to death	but not resulting	in the u	nderlying c	ause give	en in Part I.		23e. Did to	bacco use	contribute to	the cause of deatl	h?
rd	w require been sig should b										1 🗆 Y	es 22N	lo 3□Pro	bably 4 □Unkr	nown
Records,	law reas be	pie									24a. Was a autop:	sv	4b. Were aut	opsy findings avai	ilable e of
	The la	Completed									perfor 1 ☐ Yes		death?	2 No	
of Vital	Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only or				
of	Phya r this ral dir	- To	1 Yes 2 No 27. Manner of Death	1 Inpa		utpatier Time or		/A	4 LINU		me 5 eside 28d. Describe h			ify)	
on	Attending Ir death. ector: After by the funer	tion	1. ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, L	Day Year)	Injury	М	8c. Injury Work 1 🔲 1	(? Yes 2 🔲			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
Division	Attendi r death. ector: A by the fu	ifica	3 ☐ Suicide 6 ☐ Could not to determined	28e, Place of	Injury - At home, fo	arm, str	eet, factory	, office			28f. Location (S City or Tow		lumber or Rui	al Route Number,	
Ö	s afte	Certification:	4   Homiciae	building,	віс. (Зреспу)						City of Town	n, Siale)			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying P	hysician: To the bearing	st of my knowledg	e, deat	n occurred	at the tim	e, date an	d place, th occurr	and due to the c	ause(s) and	d manner as	stated.	
	the hin 24 the F	Med	one)	and manner	stated.			. License					igned (Month		
	To To	-	29b. Signature and title of certifier	X .,	Mat		230	0	/ 7/3	0			-/9 ·0		
Λ	(		30. Name and address of person who	completed cause of	f death (Item 23a)	(Type	Print)	1/4	1115	,	4.5.		110.	,	
K	6		Chitra Venkatra	· ·	6201			t Rd	. #U	J3 C	ollege	Park.	MD. 2	0740	
	Sta		31. Date filed (Month, Day, Year)	37 Regis	strar's Signature	- 4					J				
	Regist	rar	MAY 1 9 200	05 Seen	w St ,	400	with the same								

		•	State of Maryland	d / Depa		Health and	Mental Hyg	_	) 0 5	i 8	567
Physic		1. Decedent's Name (First, Middle, Last)  Lucille Catherine	Robey			-	2. Date of Deat Month May 13,	h Day 2005	Yeer	3. Time o	of Death p M
/Med Exam			4a. Facility Name (If not institution, give street and number)					4c. County of Deeth  Montgomery			
Funera Directo		Manor Care- Potomac  5. Social Security Number  217-44-0452  6. Sex	7. Age (In yrs. II	ast birthday) Yrs.	If Under 1 Ye.  Months Day	ar If Under 24 Hrs			9. Birth	place (State ntry) ington,	or Foreign
D		Usual Residence of Decedent  10a. State 10b. County  Maryland Montgo		, Town or Lo	cation					10d. Inside (	City Limits
with the	i Director	10e. Street and Number 10718 Potomac Tennis	Lane		10f. Zip Code 20854		1	0g. Citizen of US		ntry?	
paritified (s) Mary failed A. I. A. 1. 2000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ir a Medical Examinar countries any injury or other traumatic event, Ir a Medical Examinar countries.	by Funerai	1 X Never Married 2 Married	2. Was Decedent Ever in U.: Armed Forces? 1		Was Decedent of If Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puer No Specify:	Specify Yes or No- to Rican, etc.)		ck, White	can Indian, etc. nite	
rithin 72 hours in the "natural", on the "natural", on the "natural", on the control of the cont	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	life.	DO NOT use ret	cupation ne during most of wo ired)				·	
yland 21	To Be Cor	12 17. Father's Name (First, Middle, Last) Charles E. Robey		Sec	retary		's Name (First, Middle, Maiden Sumame)  I. Donaldson			ment_	
IVIGITY  nd 2 shoul  aith and Me  27 is mark  r traumati	-		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura							p Code)	
Definition of the pages 1 are potential to the pages 1 are mportential from any lojury or other pages 1 are pages	2	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		morial Park 2005 Rockville, Mary						
Date permit. Departin Importe any Inju	o o o o o o o o o o o o o o o o o o o	21. Signature of Funeral Service Ligense	Japa-			dress of Facility Collins Fundations of the Collins Fundation of the Collins Fundation of the Collins of the Co		Inc. ring, M	2090.	ı.	
Physiciai /Medica		23a. Part 1. See the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Advanced Dementia  Due to (or as a consequence of):									
te be executed  Sysician and solution in burial-transit						Years					
death certifica e attending ph	Physician/Medica	Q.	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3[	⊒Ectopic pregna ⊒ Other (specify,				ate of delive	ery Day	Year
v 8 2 8	à	Pnei monia	ditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to 1 \( \text{Yes} \) 2 \( \text{No} \) 3 \( \text{P}								
The law ate has b page 2 sl	Completed	1		-			24a. Was a autops perform	ned?	Were aut prior to codeath?	opsy finding ompletion of 2 \( \text{No} \)	s available cause of
n Or ng Phys fter this aneral di	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. l		-	one) idence 6 □Other (Specify) how injury occurred			
IVISION ATTENDED TO ATTENDED T	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, st		28f. Location (Si City or Town		ber or Rui	al Route Nu	mber,	
Hospite 4 hours Funera	edical	29a. Certifier 1 Certifying Phys (Check only one)  2 Madical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, deat tion and/or in	th occurred at the	e time, date and plac ny opinion, death occ	e, and due to the curred at the time, d	ause(s) and mate and place	anner as , and due	stated. to the cause	(s)
To the within 2 To the complet	M	29b. Signature and title of certifier	PIM.		29c. Lic	ense number d31319	2	9d. Date sign	ed (Month		
2		30. Name and address of person who con Loreto Albiol, M.D.	mpleted cause of death (Item 8218 Wiscons			Bethesda, I	MD 20814				
S Regi	State strar	1//01/ 1 0 0000	32 Registrar's Signa	ture	ule						

			For State Registrar	State o	f Maryland	-	rtment of H		-	iene	J5	18568
	0		Decedent's Name (First, Middle)	, Last)					2. Date of Deat	h _	Vear	3. Time of Death
	Physicia /Medic		Eva Olga May						Month May		005	2:15 p M
	Examin		4a. Facility Name (If not institution	-				Location of Death		4c. County	of Death Carroll	
			2025 Morning 5. Social Security Number	6. Sex	7. Age (In yrs. lasi	t hirthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		O Dish	In (Cha to 1 " i
	Funeral Director		579-18-0868	1 ☐ M 2 🔯 F	83		Months Days	Hours Min.	NOV 30	<sup>Y</sup> aar) 1921	Cour	Germany
	ס		Usual Residence of Decedent		10.00							
	arylar show	_	10a. State 10b. County		10c. City, T						1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ne Ma	ecto	MD Ca	rroll		Westm	inster		1	0g. Citizen of V	Mhat Caur	
	with t	ä	2025 Morning V	iew Drive	7			157	,	-	SA	iu y s
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or Items 23a or 28a-1 show ant, the Medical Examilinar must be indiffied at	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U.S.	13. V			ecify Yes or No-	14. Rac	e - Americ	
0	or Ite										ck, White, etc.	
200	ural',	d by	3 ★ Widowed 4 Divorced Year or Dates:							AATT	ite	
ה ה	"nati	Completed	15. Deceden (Specify only highes	st grade completed)		16a. Deced <i>(Give)</i> life. L	ent's Usual Occupa kind of work done o OO NOT use retired,	ation Juring most of work )	ing	16b. Kind of Bi		
7 7	withii iene. than	dwo	Elementary/Secondary (0-12) College (1-4or 5+) 2 Administrative Assista						Agenc			
2	other rent,	a)	17. Father's Name (First, Middle,					18. Mother's Name		-	16)	
yland	uld be denta rrked rrked	To B	Reinhard Rich	ard Paul	May			Olga E	mma Kand	ale		
Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiliating must be inclifted at once.		19a. Informant's Name/Relations Eve Ferguson/o			19b. Mailin 2025	g Address (Street a Morning	and Number or Run View Dri	al Route Number, Ve West	City or Town, Minstel	State, Zip	<sup>Code)</sup> 21157
nore,	ages 1 a int of Hea t: If item y or othe		20a. Method of Disposition  1 □ Burial 2 □ Cremation  4 □ Donation 5 □ Other (S		cem	netery, cren	sition (Name of natory or other place 11 Cemete	9)	) 2005	20c. Location - Suitla		
baltimor	permit. P Departrie Importen any inj rr		21. Signature of Funeral Service			13	Name and Afgras	iera i Hom				21157
			23a. Part1. Enter the disease, or	complications that	caused the death.		12 Washir or the mode of dying					21157 Approximate Interval Between
	Physician		shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.		Seps	8				Onset and Death
	/Medical		disease or condition resulting in death)	Due to	(or as a consequer	nce of):	3,423	13				(80)3
	Examiner		Sequentially list conditions.	b	b							
	sit s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequer	nce of):						
_	be executed ician and burial-transit	хаш	that initiated events resulting in death) Last	c. Due to	(or as a consequer	nce of):						
00/	sician buria	icai E										
200	certificate nding phys Ise as the	ਰ		0.								
O. BOX	death e atter	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	itcome of pregnanc birth 2 ☐ Fetal de nant at time of deat nown	eath 3	Ectopic pregnancy Other (specify)			23d. Dai Mo	te of delive nth	ery Day Year
ŗ.	requires that the een signed by th nould be detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause									ne cause of death?
ords	quires n sigr ald be	d by							1 □ Y€	s 2 No	3 🗌 Prob	abiy 4 Dunknown
ပ	≥ Q Q	ompleted							24a. Was a			psy findings available
T.	The la ate ha	шо							autops perform	ned2/	death?	npletion of cause of
g	ysician: The lav is certificate has director, page 2	BeC	25. Was case referred to medica examiner?					26. Place of Deat				
01 <	ys dis	ို	1 ☐ Yes 2 ☑ No			R/Outpatien		4 Indising Ho		nce 6 Oth		1)
	ding Ph h. After th funeral	ion;	27. Man or of Death 1 Natural 5 ☐ Pendir	ly .	of Injury oth, Day Year)	8b. Time of Injury	28c. Injury Work	rat k? Yes 2 □ No	28d. Describe ho	w injury occuri	ed	
VISION	Attending r death. ector: After by the fune	ertificati	2 Accident investi 3 Suicide 6 Could	not be	e of Injury - At home	e farm str		162 2   NO	28f. Location (St	reet and Numb	er or Rura	l Route Number
2	after of Direction by	ertif	4 Homicide determ		ling, etc. (Specify)	o, iaiii, siii	set, ractory, office		City or Town			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	To the Hospital or Attentwithin 24 hours after deall To the Funeral Director: completely filled in by the	0		ng Physicien: To th								
	n 24 l n 24 l he Fu	edical	(Check only 2 Medical one)	Examiner: On the tand man	pasis of examination nner stated.	n and/or inv	estigation, in my or	oinion, death occur	red at the time, da	ate and place,	and due to	the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifie	C. Nel	'MO		29c. License		2	9d. Date signe	-	
	1015L			92	17		100	059943		LISA	13,2	.005
	70		30. Name and address of person	as space	ANR. SUL	× 31	of vest	w we ten in	M0 2	1137		
	Sta Registr		31. Date filed (Month, Day, Year)	7 2005	Regionar's Signatur	#	bode					
_												

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Year **Physician** May 17, 2005 3:52 P /Medical Robert Andrew Rawlings 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) 1 X M 2 □ F Months Days Director 578-28-6583 1925 Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "naturel", or Items 23e or 28e-1 show any injury or other treumetic event, the Medical Examination and once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Prince George's Maryland Upper Marlboro 10e. Street and Number 10g. Citizen of What Country? 12907 Brooke Lane 20972 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Owner/Operator Painting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Andrew Mellwood Rawlings Mary M. Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian Rawlings-Wife 12907 Brooke Lane, Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. 05-23-2005 Clinton, MD 22. Name and Address of Facility
Huntt Funeral Home 21. Signature of Funeral Service Licenses M00053 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician ACUTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner g physician and as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed 0 V Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by ATRIAL FAILURE, DHON-INSULIN DEPENDENT 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown LITUS BLEFT VENTRICULARDYS FUNCTION 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? EFFUSION, S) POSSIBLE ASPIRATION PRODUCTION 1 10 Yes 2 No 1 TYAS 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural s after dea. ••I Director: After 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident n 24 hours.
the Funerel Directory filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature, and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MERAMMER A. MANNAM 2459 30. Name and address of person who completed cause of death (item a MOHAM WED) A: WANNAM TOLEDO J(W) TSVILLE 32. Regetrar's Signature 31. Date filed (Month, Day, Year) MAY 1 9 2005 Registrar

			1 For 1 State	State of Man	yland / De	epartment of I	Health and	•	giene 005	18570	
			1 - State Registrar  1. Decedent's Name (First, Middle, Last	)		Certificate of	Death	2. Date of Dea	Reg. No.	3. Time of Death	
	Physici	an		_				Month	Day Year	P	
	/Medid Examin		Dorothy Marie Ri  4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Deat	h	4c. County of Dea		
	LAGITIII	iei	Washington County			Hage	rstow	n	Wast	ninaton	
	Funeral		5. Social Security Number 6. Se		n yrs. last birtho	Months Days	If Under 24 Hrs	8. Date of Birth		rthplace (State or Foreign	
	Director		578-14-6155	JM 26JF	89 Yr	s. Montale Baye	110010	Jan. 9,	1916 Mar	yland	
	and w		Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town o	r Location				10d. Inside City Limits	
	Mary f sho	ro	Maryland Washingt	on	Hane	cock				1 □ Yes 2√□ No	
	r 28a	Directo	10e. Street and Number		-	10f. Zip Code			10g. Citizen of What C	ountry?	
	death with the Maryland rms 23a or 28a-f show r.must be notified at		3204 Old Deneen R	oad			21750		United States		
	r dea	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	<ol> <li>Was Decedent of If Yes, specify Cut</li> </ol>	Hispanic Origin? (S can, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh		
20	hours after lural', or Ite	by Fu	1 Never Married 2 Married  X  Widowed 4 Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:		1□ Yes X No			Specify:	White	
2-003p	hour	ed b			16a. D	ecedent's Usual Occu	pation		16b. Kind of Busines	s/Industry	
<u>ე</u>	within 72 ene. than "nat he Medic	plet	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(C	ive kind of work done fe. DO NOT use retire	during most of wo	rking		,	
7	filed with Hygiene other the	Completed	12			Nurse			Health	Care	
/Iand	m - 0 %	Be	17. Father's Name (First, Middle, Last)						Maiden Sumame)		
<u>X</u>	should ind Men s marke umatic	ပ္	James Walter R		- Vancai			le C. Ric			
g Z	d2sh thanc 7 Is n traun		19a. Informant's Name/Relationship (7)  Roland L. Jones /		320	4 01d Dene	ed Rd., F	u <i>rai H</i> oute <i>Numb</i> e. Hancock,	r, City or Town, State, MD 21750	Zip Code)	
<u>6</u>	permit. Pages 1 and 2 should be Department of Health and Menta Important: If them 27 is marked any injury or other traumatic es	-	Rolland 2. Colled , Toll							r Town, State	
saitimore,	Pages nent of I int: If its		1 ☐ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	Darnest	own Church	Cem. 5/1	19/2005	Darnestown	, Maryland	
<u>=</u>	permit. Page Department of Important: If any injury or onct.		21. Signature of Funeral Service Lidens	99/		22. Name and Addr			r Funeral		
'n	9 0 E 8		/ outney	tauffer			_		Frederick,	MD 21702	
		1	23a. Part1. Enter the use is or compleshock, or heart mile. List only o	ications that caused the ne called in each line.	e death. Do not	enter the mode of dy	ing, such as cardia	c or respiratory arr	rest,	Approximate Interval Between	
	Physician	(	Immedial Cause (Final dis- or condition ulting in death)	Resh	ivato	rux Fai	ling			Onset and Death	
	/Medical- Examiner		resulting in death)	Due to to as a	nsequence of)	_0				3 10	
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	uted d ansit	Examiner	Sequentially list conditions, francy, loading to minimadiate cause. Enter Underlying Cause (Disease or injury that initiated events	Chroniz	16	character.	e Pallon	a. d.	> 41.0	3 5	
'n	be executed ician and burial-transit		resulting in death) Last	Due to (or as a co	onsequence of)	· · · · · · · · · · · · · · · · · · ·	P. Carrier	J	t cp	-9	
2/00	e ys	cal		d							
200	w requires that the death certilica been signed by the attending ph should be detached for use as th	by Physician/Med	IF FEMALE:								
X O D	death ce e attend ed for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death	3 Ectopic pregnand	у		23d. Date of de Month	livery Day Year	
- 5	the de	yslc	1 Yes 25 No 9 Unknown	4□Pregnant at tim 9□Unknown	ie of death	5 ☐ Other (specify) _				,	
<u>,</u>	requires that the een signed by th nould be detache	y Ph	Part II. Other significant conditions co	ntributing to death but n	ot resulting in th	ne underlying cause gr	ven in Part I.	23e. Did to	bacco use contribute (	o the cause of death?	
202	quires n sign								es 2□No 350F	robably 4 Unknown	
ecor	law recast bee	ompleted						24a. Was a		utopsy findings available	
Ľ	0 4 0	Com						autops perfor	med?   death?	completion of cause of s	
VITAI	ysician: The is certificate director, pag	BeC	25. Was case referred to medical examiner?					ath (Check only or			
0	S 0 0	ို	1 Yes 2 No	lospital:	2 ER/Outpa	Ment 30 DOX			ence 6 ☐ Other (Spe	ecify)	
	ling After fune	lon	27. Manner of D ath  1 Satural 5 Pending	28a. Dite of Injury (Month, Day Ye	ear) 28b. Tim Inju	ry Wo	ary at ork? ]Yes 2 □ No	28d. Describe h	ow injury occurred		
UNISION	r Attender death rector:	flcat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	- At home, farm	, street, factory, office		28f. Location (S	treet and Number or F	ural Route Number.	
2	al or Attending F s after death. I Director: After d in by the funer	Certification:	4 Homicide determined	building, etc. (	Specify)	, , , , , , , , , , , , , , , , , , , ,		City or Town			
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of m	ny knowledge, d	eath occurred at the t	ime, date and place	and due to the c	ause(s) and manner a	s stated.	
	the H nin 24 the Fi	edical	one)	and manner stated	i.						
	with To Con	Σ	29b. Signature and title of certifier			29c. Licen	se number		Sol. Date signed (Mon		
	~/		30. Name and address of person who co	ompleted cause of door	h (Itam 222) (T	ne Print)	5232	>	3/10/	1	
	18		D Waller	1126-081	4	urt /	43 Mc	1217	42		
	Sta		31. Date filed (Month, Pay, Year) 8 2	005 32. Panistrar's	Signature	Locale )	/				
Ì-	Registr	ar	3717 17 12 0 -	100000		A STATE OF THE PARTY OF THE PAR					

# Shelton, Rosabell Baltimore. Maryland 21215-0036

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
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			1 - Stata Registrar		artment of Health and M tificate of Death	Mental Hygier Reg. 1 2. Date of Death	2000	18571			
1	Physici	an	Decedent's Name (First, Middle, Last)     ROSABFIL	Day Year	3. Time of Death  12:55 P M						
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Doctors Hospital	SHELTON	4b. City, Town, or Location of Death Lanham	4c. County of Death Prince George					
	Funeral Director		579-09-9384 1DM XDF	ge (In yrs. last birthday) 86 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea October 25,	9. Birthpla County 1918 Washing	ace (State or Foreign y) pton, DC.			
	a-f show	ctor	Usual Residence of Decedent  10a. State  10b. County  C.	10c. City, Town or Lo			10	d. Inside City Limits 1 XYes 2 □ No			
	h with the 23a or 28 181 be no	al Director	10e. Street and Number 2420 36th St. SE.		10f. Zip Code 20020	10g.	Citizen of What Countr USA	ry?			
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Armed Forces, 1 Yes 2 Diff Yes, Give Year or Dates:	No I	Nas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto I □ Yes XIXNo Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, et Specify: Bla	tc.			
21215-0036	filed within 72 ho Hygiene. ther than "natur ont, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or	(Give life. L	tent's Usual Occupation kind of work done during most of work DO NOT use retired) Cations Specialist	Co	16b. Kind of Business/Industry  Government				
Maryland 2	12 should be filed within h and Mental Hygiene. 7 Is marked other than "Iraumatic event, Ira Mes	To Be C	17. Father's Name (First, Middle, Last)  Jerry	Wilson		e (First, Middle, Maid	Dixon				
	1 and 2 shou Health and M em 27 la mai		19a. Informant's Name/Relationship (Type, Print) Gloria Gross, Daughter		g Address (Street and Number or Run 36th St. SE Washi			Code)			
Baltimore,	Pa ant ant		20a. Method of Disposition  ¹X Burial 2 ☐ Cremation 3 ☐ Removal from State  ¹ 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo		Date 20c.	Location - City or Tow tland, MD.	rn, State			
Balt	permit. Pag Department Important: I any injury o		21. Siriat of Funeral Service Licensee	llusm Bia	Name and Address of Facility Panchi F.S. 814 Upshur		ngton DC 2001	11			
	Physician /Medical		23a Part . Exter the disease, or complications hat cause shock of heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death)  Due to (or as		er the mode of dying, such as cardiac cossisting.	or respiratory arrest,		Approximate nterval Between Onset and Death			
8760,	ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):								
O. Box 6	The law requires that the death certificate be executed tte has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy		: 23d. Date of delivery Month D	/ Day Year			
rds, P.	quires that in signed build be det		Part II. Other significant conditions contributing to death to	hypek M-	nderlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown				
al Records,		Completed by				24a. Was an autopsy performed?	prior to comp death?	sy findings available pletion of cause of			
n of Vital	ding Phyaician: Th h. After this certificate funeral director, pag	n: To Be	25. Was case referred to medical examiner?  Hospital: 1 Inpati 27. Manner of Death  28. Date of Inj Month De	h <i>(Ch</i> eck only one) me 5 Residence 28d. Describe how in	6 □Other (Specify) jury occurred						
Division	l or Attending after death. Diractor: After i in by the funer	27. Mannap of Death   Natural   S   Pending investigation									
_	Hospital 4 hours Funeral ely filled	edical Co	29a. Certifier (Check only one)  Certifying Physician: To the best on the basis of and manner st	f examination and/or inv	occurred at the time, date and place, restigation, in my opinion, death occurr	and due to the cause red at the time, date a	(s) and manner as stat and place, and due to the	ed. ne cause(s)			
)	To the To the Complet	Me	29b. Signature and title of certifie	- mo	29c. License number		Date signed (Month, Da				
_	De			1 mg 95	Print) AMARCLIS	Bd, C	Apha mo	20766			
	Sta Registr		MAY 1 9 2005	ar's Signature							

			1 - For State Registrar	State of Maryland	d / Depa <i>Cer</i>	irtment of H tificate of L	ealth an Death	d Mental Hy	giene Reg. No.	005	185	72
			1. Decedent's Name (First, Middle, La	st)				2. Date of De Month	eath Day	Year	3. Time of t	Death
	Physici /Medio		Brigitte	Stanford						005	1206	p M
	Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of 0	Death	4c. 0	County of Death		
			University Of			Balti						
	Funeral		5. Social Security Number 6. S	lex 7. Age ( <i>In yr</i> s. <i>I</i> s ☐ M 24☐ F 1 7	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Bi Min. (Month, Di	rth a <i>y</i> , Year)	9. Birthp Cour	lace (State or itry)	Foreign
	Director		515-96-8705 Usual Residence of Decedent	1,	TIS.			05-11-	1988	W. G	erman	У
	and we		10a. State 10b. County	10c. City	, Town or Lo	cation				1	Od. Inside City	Limits
	Mary f sh	ō	MD Prince	Georges	Tem	ple Hil	1s				1 🔀 Yes	2 🗌 No
	288	Director	10e. Street and Number		_	10f. Zip Code		1	10g. Citiz	en of What Cour	ntry?	
	3a ol	i D	5949 Fisher Rd	#13		20	748			USA		
	death ms 2	Funerai	11. Marital Status	12. Was Decedent Ever in U.S	S. 13. V			? (Specify Yes or No uerto Rican, etc.)		4. Race - Americ		
9	after or ite	Ē	1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No		_		'uerto Hican, etc.)		Black, White,		
8	ral', c	l by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		☐ Yes 2½ No	Ѕреспу:		5	Specify: B	1ack	
5-0	72 h natu lical	Completed	15. Decedent's E (Specify only highest gra		(Give	ent's Usual Occupa	luring most of	workina	16b. Kin	d of Business/Inc	dustry	
7	Athin ne. han "	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	(NOT use <i>retired</i> Stude		•	Pr	ivate		
2	lled v tygie har t		17. Father's Name (First, Middle, Last	<u> </u>				Name (First, Middle				
and	l be fintal Hed of	Be	_							,		
Ë	hould d Me mark maric	ဥ	Roy  19a. Informant's Name/Relationship (	Stanford	10b Mailin		Eliza	Detn or Rural Route Numb	Has		Code	
N N	d2s than than 7 ia t		Roy Stanford/					13 Temp1				4.8
Ġ	1 an Heal Iam 2		20a. Method of Disposition	20b. Pl	ace of Dispos	sition (Name of	1	Date		ation - City or To		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent, the Medical Exertine the retified at once.		1X Burial 2 ☐ Cremation 3 ☐	Hemoval from State Clas	nmetery, cren nwood	natory or other place Cemeter	ry 5-	21-2005				
₽	artme artme ortan injur:		*4 ☐ Donation 5 ☐ Other (Special 21. 5 nature — uneral Servige Lices	" 2								_
Ba	Dep Impe		I monald	7.6	1 1 1 2 2			Taylor's 1 St. NW				2000
			23a. Part1. Enter the disease, or com	plications that caused the death						ningto	Approximate	
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.							Onset and De	en ath
	/Medical		disease or condition resulting in death)	Due to (or as a consequ		Injury						
	Examiner							2	187			
	_ =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury	Due to (or as a consequ	ence of):			10	Ham			==
	icate be executed physician and s the burial-transit	Examiner	that initiated events	c.				1 July		1		
Ö,	e exe ian a urial-	Ë	resulting in death) Last	Due to (or as a consequ	ence of):		1	1 Kg e.	/			
8760,	ate b hysic the b	dical		d			1					
9	entific ling p	Med	IF FEMALE:	00-11		4		Cultur				
Вох	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3□	Ectopic pregnancy	CERT		23	<li>id. Date of delive Month</li>	ry Day Ye	ar
o O	t the de by the a tached t	ysic	1 ☐ Yes 2 ☒No 9 ☐ U⊓known	4□ Pregnant at time of de 9□ Unknown	ath 5	Other (specify)						
<b>a</b>	that the by detac	'Ph	Part II. Other significant conditions of	ontributing to death but not resu	Iting in the un	dertying cause give	n in Part I.	23e. Did 1	tobacco use	e contribute to the	e cause of dea	ath?
ds,	The law requires that the death certificate has been signed by the attending Is agge 2 should be detached for use as	d by				, ,		10	Yes 2.⊠	No 3 ☐ Prob	ably 4 ∐Un	known
Record	w req beer shou	Completed						24a. Was	30	24b. Were autor	new findings as	vailable
Re	ne lav s has ge 2	mp						autor	psy ormed? 2 No	death?	npletion of cal	ise of
		e Co	25. Was case referred to medical					<del></del>		1 🗆 Yes	2 No	
Vital		o Be	examiner?	Hospital: 1   Inpatient 2 □ E	ER/Outpatient	Othe	<i>r</i>	Death (Check only		D0** /G*		
o	Phys or this oral di	-	27. Manner of Death		28b. Time of	28c. Injury Work	4 🗀 1401511	ng Home 5 ☐ Resi 28d. Describe			"	
0	th. : After s funer	tio	1 ☐ Natural 5 ☐ Pending 2 🖾 Accident investigation	28a. Date of Injury (Month, Day Year) 0 4 - 2 1 - 2 0 0 5	0629		? ′es 2⊠No	Motor	Vehi	cle Ac	ciden	t
Division of	a Hospital or Attendi 24 hours after death. a Funeral Director: A stely filled in by the fu	ertification:	3 ☐ Suicide 6 ☐ Could not b	28e. Place of Injury - At hor building, etc. (Specify,	ne, farm, stre	et, factory, office		28f. Location (	Street and	humber or Qura	(Revite Nyrob)	Υ.
	i gite	ert	4 ☐ Homicide determined	Stree						boro, l		
	pspita hours inera y fille	alc	29a. Certifier 1 Certifying Pr	ysician: To the best of my know	vledge, death	occurred at the time	e, date and p	lace, and due to the	cause(s) a	nd manner as sta	ated.	
	To tha Hospital within 24 hours a To tha Funeral I completely filled	Medical	(Check only 2 Medical Example)	niner: On the basis of examinati and manner stated.	on and/or inv	estigation, in my op	inion, death o	occurred at the time,	date and p	lace, and due to	the cause(s)	
	To tha within 2 To tha complet	Ž	29b. Signature and title of certifier	().		29c. License	number			signed (Month, L	,	
			KLX (V). D	nd h	N	P166	510		05/	18/200	5	
2	(1)		30. Name and address of person who	completed cause of death (Item	23а) (Туре, Р	Print)						
			Sharon A. Swen	cki 419 Redwood		et Suite	280 Ba	lt. Md. 2	1201			
	Sta	_	31. Date filed (Month, Day, Year)	2. Registrar's Signate								
	Registr	ar	MAY 1 9 200	Diam A	14 may							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1- State Registrar AMEND ITEM #12&15 PER CH C8/14 6/13/05 JH 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year /Medical Wood Shockley May 13, 2005 11:12 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1306 Allenwood Drive Salisbury Wicomico tf Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 3/9/1928 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1XXM 2□ F 222-16-1044 Yrs Director 77 Tennessee Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at 1 XYes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1306 Allenwood Drive 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after Heaves 2000 If Yes, Give Year or Dates: 1 Never Married 2000 Married 1 ☐ Yes 2 ☒ No Specify. þ white 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Industrial Water Elementary/Secondary (0-12) College (1-4or 5+) 12 4+5+ Treatment Chemical Engineer permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othingury or other traumatic event. 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame, Henry Wood Shockley Cybil Copps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Shockley/wife 1306 Allenwood Dr., Salisbury, MD21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/18/2005 \* 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD Funeral Service Licenses 22. Name and Address of Facility avid Holloway Funeral Home Professional Association 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical **Examiner** Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner use as the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical JF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the aid be detached for 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown been 24a Wasan 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Yes 2 No in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check onl. one Ho spital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification; To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 Naturat 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director: filled completely

Maryland 21215-0036

Baltimore,

State Registrar

29a. Certifier

29b. Signature and title of certifier

Kopers 15 conten 10.0. 1205 32.. gistrar's Signature 1'8 2005 marke

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Ens

~ 210.0

29c. License number

H00203X

29d. Date signed (Month, Day, Year)

Spector Ida 5/16/05 12.15AM

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene )

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ς,	15:AM		For State Registrar	State of W	-	ertificate of			Reg. No.	15 18574				
	Physici	an	1. Decedent's Name (First, Middle, La	st)				2. Date of De Month		3. Time of Death				
	/Medic		Ida Goldie Spec					May	16 200	05 12:15 A <sup>M</sup>				
4	Examin	er	4a. Facility Name (If not institution, give	_			or Location of Death		4c. County o					
			Suburban Hospit  5. Social Security Number 6.5		e (In yrs. last birthda	Bethesda If Under 1 Year		8 Date of Bird	Montgo					
	Funeral Director		105-09-4455	1□M 2∏F	93 Yrs	Months Days		8. Date of Bird (Month, Da 11/25/1	y, Year) 1911 N	9. Birthplace (State or Foreign Country) New York				
	w.c		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits				
	Many -1 she	tor	MD Montgom	ery	Rockvil	1e				1 XYes 2 ☐ No				
	r 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of Wi	hat Country?				
	th with	Funeral Director	6111 Montrose Roa	d Apt-215		20850			United	States				
	r dea	ıner	11. Marital Status	12. Was Decedent Amed Forces?	Ever in U.S. 1	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race Black	- American Indian, , White, etc.				
Maryland 21215-0036	be filed within 72 hours after death with the Maryland nial Hygiene. so other than "natural", or Items 23a or 28a-1 show event, the Madical Examiner must be notilized at	by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 X If Yes, Give Year or Dates:	No	1 ☐ Yes 2 💢 No				White				
5-0	72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. De	cedent's Usual Occupive kind of work done  b. DO NOT use retire	pation during most of work	king	16b. Kind of Bus	iness/Industry				
121	e filed within al Hygiene. I other than "	mpi	Elementary/Secondary (0-12)	College (1-4or	0+)	e DO NOT use retire emaker	ed)		Own Ho	.m.o				
<b>d</b> 2	filed Hygie ther		17. Father's Name (First, Middle, Last	)	HOIII	emakei	18. Mother's Nam	e (First, Middle,	Maiden Sumame					
an	uld be fental rked o	To Be	William Lasser				Lena Si		,					
ary	s 1 and 2 should be f Health and Mental item 27 is marked other traumatic ev	-	19a. Informant's Name/Relationship (	Type, Print)	19b. Ma	ailing Address (Street	and Number or Rui	al Route Numbe	er, City or Town, S	itate, Zip Code)				
	is 1 and 2 of Health a item 27 is		Phyllis S Fisher	- Daughter		Hyde Cour		Spring,	MD 2090	)2				
ore	of He		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	TRamoval from State	20b. Place of Dis cemetery, of	sposition (Name of rematory or other pla	ice)	Date	20c. Location - C	City or Town, State				
Ĕ	Pag ment ant:		`4 □Donation 5 □ Other (Speci	(y)	Mt. Leba	ebanon Cemetery 05/18/2005 Adelphi, MD								
Baltimore,	permit. Pages 1 an Department of Heal Important: if item 2 any injury or other		21. Signal are of Fight Service Lace	see ()	1000	22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave Silver Spring, MD								
	40260		23a. Part1. Enter the disease, or com	unlications that cluses						ring, MD 20904				
	7447 E.		shock, or heart failure. List only	one cause on each li	ne.	- 27			rest,	Interval Between Onset and Death				
	/Medical		disease or condition resulting in death)		AEMIC a consequence of):	CART	HOLHOL	ATHY						
P	Examiner			Lei	n A TT TU									
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		2	IF FEMALE:	23c. If yes, outcome	of pregnancy				23d. Date	of delivery				
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ecc	law asb	ple						24a. Was	osy pri	ere autopsy findings available ior to completion of cause of				
=	The cate ha	Completed						1 Tes	rmed? de	eath? ☐ Yes 2 No				
Vita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0#	26. Place of Dear							
of	Phys this ral dii	. To	1 ☐ Yes 2√☐ No 27. Manner of Death	28a. Dat of Inju		e of 28c Inu	her: 4 Nursing Ho		dence 6 Other					
on	Attanding F r death. sctor: After by the funer	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year) Injur	y Wo	rk? Yes 2 □ No	Loc. Dosonbo	ion injury occurred	1				
Division	Attan deal sctor	ifica	3 ☐ Suicide 6 ☐ Could not b	28e. Place of Inj	ury - At home, farm,	street, factory, office				r or Rural Route Number,				
ā	al or s afte al Dire	Certification:	4 Homicide	building, et	c. (Specify)			vn, State)						
	To the Hospital or Attant within 24 hours after deatl To the Funeral Director: completely filled in by the	edicai	29a. Certifier (Check only one) Certifying Pl	nysician: To the best miner: On the basis of and manner st	f examination and/or	eath occurred at the till investigation, in my o	me, date and place, opinion, death occur	cause(s) and mani date and place, an	ner as stated. Id due to the cause(s)					
	To th within To th	Me	29b. Signature and title of certifier		~ A4 D	29c. License number 29d. Date signed (Month, Day, Year)								
)	3		Alpeny	ma	7 M.D.	3a) (Type, Print) ROCKWILLE PIKE, ROCKWILLE; MD 20 PSY  TO Sports								
			30. Name and address of person who	completed cause of o	leath (Item 23a) (Typ	pe, Print)	0111=	0/2/11/11/	F. NO	20854				
			ALPANA GOSWA	AHI M.D.	////9 No	saculat	rive 1	- Cacore	- 1 100					
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 8 2	005 Harry	a s Signature	rever								
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	-	For State Registrar		State o	of Maryl	and /	•	artmen tificate				lental H	lygien Reg. N	2111	)5	18	57
Physicia	an	Decedent's Name	(First, Middle, Maybe)		SIL	ov.						2. Date of Month MAY		<sup>ay</sup> 200	Year	3. Time o	
/Medic	al	4a. Facility Name (If						4h City	Town or	Location of	of Death	MAI		c. County		3:30	) A
Examin	er			IERAN VIL						TOWN	or Boatti			WASH		ON	
Funeral		5. Social Security N	-	6. Sex	7. Age (In		, ,	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of	Birth Day, Yea		9. Birth	place (State	or Fore
Director		118-10-7		1 □ M 2 🖾 F		96	Yrs.	MONUIS	Days	nouis	WHIT.	May 6	, 19	ő9	New	York	
pug *		Usual Residence of 10a. State	Decedent 10b. County		10c	City, Tov	wn or Lo	cation								10d. Inside (	Lity Lim
Aaryle f sho	0	Marvland	Washir	ngton				town								1 <b>2</b> □ <b>3</b> Yes	2 🗆 1
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or Items 23a or 28e-f show any injury or other treumatic event, Ita Madical Examinating matter and the angue.	Funeral Director	11. Marital Status		12. Was Dec	edent Ever orces?	n U.S.	13.	Was Deced	lent of Hi	spanic Or n, Mexicai	igin? (Sp n, Puerto	ecify Yes or Rican, etc.)	No-		e - Ameri k, White,	can Indian, etc.	
s afte	by Fu	1 Never Marri	_	If Yes, G	2 X No			1 🗆 Yes						Specify	wł	nite	
hour tural	q pa	3 L24VIOOWed	15. Decedent	Year or I	Jates:	168	a. Deced	dent's Usua	I Occupa	ation			16b.	Kind of Bu	siness/In	dustry	
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12 should be filed within " h and Mental Hygiene." 7 Is marked other than " freumatic event, Ire Musi	To		Samuel	l Parry J	ones,							Mary			en contract to	200 5 8 3 3	
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Physician /Medical Examiner		23a. Part1. Enter the shock, or hea Immediate Cause (disease or condition resulting in death)	rt failure. List ( Final	only one cause on a al	caused the each line.	inii	ند	Deo			cardiac	or respirator	y arrest,			Approxima Interval Be Onset and	tweer
ted nsit	Examiner	Sequentially list confidence if any, leading to include. Enter Under Cause (Disease or that initiated events	nditions, nmediate nyling injury	b. — Due to	(or as a cor	nsequence	e of):										
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signed by		Part II. Other signif	icant conditio	ns contributing to	death but no	t resulting	in the u	nderlying o	ause give	en in Part	l.		id tobacc	_	ribute to t	the cause of	death Unkn
v requir been s should	lete											24a. W	has an	24b. \	Vere auto	opsy finding	s avail
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Physician: Th r this certificate ral director, pag	Be	25. Was case refer examiner?		Hospital:	74	- C - D - C			Oth			h (Check on		0 TO11	- (0	4.1	
ding Physician: h. After this certific funeral director.	: To	1 Yes 2 2		28a. Date	of Injury	2 ER/C	outpatier . Time o		28c. Injun Worl	432 N	ursing Ho	ome 5 R				Ty)	-
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To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical C	29a. Certifier (Check only one)		g Physician: To the Examiner: On the and ma													(s)
To the within 2 To the complet	Me	29b. Signature and	title of certifier	0 1	1 1					e number	- April			-		Day, Year)	
		) cua	lujon	who completed car	roy	(ltam 00-	) (Tues	Prior)	128	365		l- 1+0		-21	05		
8		30. Name and addr	oss of person	who completed car	CH10	(Item 23a	36	X K	11:20	St	ver	1- ite	age	usto	2021	1702	17
		1 17	th, Day, Year)	· • • · ·	- 11 VT	• (		when	الي ا	1	-	. ,	1	-			

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Margaret Ruth STONE 2005 323C MAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Min Hours 1 ☐ M 2 🖾 F 87 215-20-8455 Director Dec. 9, 1917 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural', or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18005 Par Three Drive 21740 USA by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: white 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) raumatic event. the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinent of Health and Mental Hygiene.
Int: if Item 27 is marked other than teacher public school 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edgar Wilbur Byer Mary Dickson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert B. Stone - son 120 N. Potomac St., Hagerstown, Maryland 21740 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☼ Cremation 3 ☐ Removal from State = 5 Department of important: If any injury or once. Hagerstown Crematory 5/20/05 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 980 If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. the þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas page 2 autopsy 240 No certificate 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2/XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 npatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 24 hours af 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the the 29b. Signature and title of certifier. May 20,2005 Type, Print) Medical Cumpus Rd Hagerstown, Maryland 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) in botham HIGG 11110 2H-10 31. Date filed (Month State Registrar

			State of Maryland				Mental Hygie	ene	10577
			Registrar  1. Decedent's Name (First, Middle, Last)	Cer	rtificate of D	veatn	Reg 2. Date of Death	No. UUJ	3. Time of Death
	Physici	_	Catherine Louise Suffecool				Month 19	Day Year . 2005	5:25 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Dea		4c. County of Death	
			Homewood Retirement Center		William			Washingto	n
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year  Months Days	If Under 24 Hi Hours Mi	n. (Month, Day, Y		place (State or Foreign ntry)
	Director		216-74-8710 1 96  Usual Residence of Decedent				August 16	5,1908 Mar	yland
	ylanc how		10a. State 10b. County 10c. City, T	own or Lo	cation				10d. Inside City Limits
	e Ma	ctol		iams	port				1 ☐ Yes 2 No
	with th	Dire	10e. Street and Number		10f. Zip Code			J. Citizen of What Cou	ntry?
	eath is 236	erai	16505 Virginia Ave.  11. Marital Status 12. Was Decedent Ever in U.S.	13 \	21795 Was Decedent of His	nanic Origin?		USA 14. Race - Ameri	can Indian
(0	r item	by Funeral Director	Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ▼ No  [If Yes, Give	1	f Yes, specify Cuban	, Mexican, Pue	erto Rican, etc.)	Black, White,	
93	ours a	d by	3XXWidowed 4 □ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: Whi	te
5-0	within 72 hours after death with the Maryland ene. than "natural; or items 23e or 28e-1 show he Medicel Exainant institutional	Completed	15. Decedent's Education (Specify only highest grade completed)	6a. Deced	dent's Usual Occupat kind of work done du DO NOT use retired)	tion uring most of w	orking 16	b. Kind of Business/Ir	dustry
12	withir ene. than	дшс	Elementary/Secondary (0-12) College (1-4or 5+)		ewife			Home	
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/lar	uld be Venta Irked Itic av	To B	John Calvin Sword,Sr.			Bessie	Talitha Br	icker	
Maryland 21215-0036	and l						Rural Route Number, C		
e, e	1 and 1ealth 9m 27 ther tr				Virginia	Ave.	Williamspo	rt,MD 2179	
Baltimore,	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: if item 27 is marked other than "natural; or items 23e or 28a-f show any njury or other traumatic avent, the Medical Examination in an analysis of the profiled at once.		1 X Burial 2 Cremation 3 Removal from State	etery, cren	matory or other place alley Cem		21-2005 C		
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			23a. Part T. Enter the disease, or complications that caused the death. I shock, or heart (dilure. List only one cause on each line.	o not ent	er the mode of dying	, such as cardi	ac or respiratory arrest	,	Approximate Interval Setween Onsepand Death
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	/Medical Examiner		resulting in death)  Due to (or as a consequent	,	Λ			•	>-(()/1.6
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		4				Y JAG
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oʻ	e exection and an arrial-tr	Exa	resulting in death) Last . Due to (or as a consequent	ce of):					
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alF							1 ☐ Yes 2		2□ No
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o l	ding Phys h. After this funeral dii	-	27. Manner of Death 28a. Date of Injury 28	b. Time of Injury			28d. Describe how		97
sior	Vttandin death. ctor: Afr y the fur	atio	2 Accident investigation	injury		es 2□No			
Division of	i or Attano after deatl Director: I in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office		28f. Location (Stree City or Town, S	at and Number or Rura State)	Al Route Number,
	To the Hospital or Attanding Physician: The within 24 burs after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 18 Certifying Physicien: To the best of my knowled	dae deet	a conumed at the time	dete and play	no and due to the sour	(-)d monage on a	totad
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	To th within To th comp	Me	29b. Signature and title of centrier		29c. License	number	29d	Pate signed (Month,	Day, Year)
)			MCHIL Theorea Mas	Tan	D1	706		Way 19,	2005
			30. Name and address of person y occumpleted cause of death (Itam 23	a) (Type,	Print)	TV-	A- 16	and of the	111
21	-0		31. Date filed (Month, Day, Year)  32. Registr r's Signature	-	14 / NOV	Tten	The 1111	OGUSTOR	en liko
	Sta Registr	•	MAY 2 3 2005	A	reste			20	742

			1 - For State Registrar	State of Ma	rylan		artment tificate				giene	1115	18578		
	Physic /Medi		Decedent's Name (First, Middle, Last)	Jeron	Q	St	ern			2. Date of De Month May 1	Day	Year 2005	3. Time of Death 7:30 a M		
	Examir		4a. Facility Name (If not institution, give 2217 Gablehammer	Road			VV	estm	Location of Death inster		4c.	County of Death	oll		
	Funeral Director		5. Social Security Number 6. Set 130-03-3085	7. Age	92	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Jul 12	th ay, Year) 19	(0)	nplace (State or Foreign untry) v York		
	Maryland e-f ehow	tor	10a. State 10b. County  Maryland Carrol	1	10c. City	, Town or Lo	cation		Westmin	ster			10d. Inside City Limits 1 ☐ Yes 2√ No		
	h with the 23a or 28 st be not	al Director	10e. Street and Number 2217 Gablehanmer	Road			10f. Zip	Code	21157		10g. Citi	izen of What Col USA	untry?		
920	be filed within 72 hours after death with the Maryland that Hygiene. So other then "natural", or items 23a or 28e-f show event, the Medical Examiner must be motified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:			Was Deced f Yes, spec		spanic Origin? (S , Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	)-	14. Race - Amer Black, White Specify: VV			
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yland	should be filed withir and Mental Hygiene. s marked othar then umetic event, the M.	To Be (	17. Father's Name (First, Middle, Last) Unknown			,			18. Mother's Nan Unknov	ne (First, Middle, VN	, Maiden	Sumame)			
	od 2 stranger trans			<sup>pe, Print)</sup> Lega Guardian		2217	Gable	eham		, Westmi	inste	r Town, State, Zi	1157		
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)		Ca	ace of Dispo emetery, cren rroll	crema	ther place ation	05/1	Date 6/2005	Ha	ocation - City or T Ampstead			
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.O. Box 68	death certific e attending p od for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of the first outcome of the first outcome of the first outcome of the first outcome outcom	2 Fetal	death 3	Ectopic pre				2	23d. Date of deliv Month	rery Day Year		
rds, P	w requires that the been signed by th should be detache	by	Part II. Other significant conditions con	ntributing to death bu	t not resu	Iting in the u	nderlying ca	luse giver	n in Part I.	23e. Did to		/	the cause of death?		
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Vita	Physiclan: this certific al director,	Be	25. Was case referred to medical examiner?	lospital:				0#		th (Check only o					
of	ding After funer	ıtlon: To	1 Yes, 2 No  27. Many-r of Death  1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatier 28a. Date of Injur (Month, Day	1975	ER/Outpatien 28b. Time of Injury		3c. Injury Work	at	ome 5 Residence 28d. Describe h		Other (Speci y occurred	(fy)		
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	To the Hospital within 24 hours a To the Funeral E completely filled	edical	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Examination	sician: To the best of ner: On the basis of and manner sta	examinati	vledge, death ion and/or inv	occurred a restigation,	it the time in my opi	n, date and place, nion, death occur	and due to the cred at the time,	cause(s) date and	and manner as s place, and due t	stated. to the cause(s)		
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	0/		30. Name and address of person who co		eath (Item	23a) (Type,	Print)	Suit	2 307	west	الماس	per m	0 21157.		
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 6	32. Regista 2005	-	ure #	bert	e o							

JET 5-03344 Marie Spates

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Amended #4a per ME, 10a per Fortificate of Death CHD 5/18/05 Tag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** MARIE-RENEE SPATES May 14 2005 8:50 Α /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Poolesville 21111 Westerly Avenue Montgomery 8. Date of Birth APRIL 9. Birthplace (State or Foreign 1928 Country) 7. Age (In vrs. last birthday Social Security Number 6. Sex **Funeral** 2°6 Days Months Hours 1 ☐ M 2 👿 F 220-34-3831 77 BELGIUM Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a State 10h County or 28e-f show treumetic event, the Madical Exerciper roust be notified at MD MONTGOMERY POOLESVILLE 1 ☐ Yes 2 No Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21111 WESTERLY AVE. Road 20837 BELGIUM Items 23a Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) FARMER AGRICULTURE 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Inent of Health and Mental Intern 27 is marked o CORNELIUS KNEPPLEHOUT de STERKENBURG MADELEINE du CHASTEL de la 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21121 WESTERLY RD., POOLESVILLE, MD 20837 ERIC SPATES / SON other 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ō MARY'S CHURCH Department of Importent: If eny injury or gace. 5/18/2005 BARNESVILLE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
HILTON FUNERAL HOME
P.O. BOX 86, BARNESVILLE, 21. Signature of Funeral Service Licenses 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final atherosclerote conditionascular disease Physician Hypertensive disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consectioned of? Examiner rsician and 9 burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical nding physi use as the l use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u Dav Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown þ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ∠Yes 2 □ No 24a. Was an autopsy performed? page certificate 2 No Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examines Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Scene Hospital: 2 ☐ ER/Outpatient 3 ☐ DQA 20 1 XYes 2 ☐ No 1 Inpatient this 28c. Injury at Work? 28d. Describe how injury occurred Date of Injury (Month, Day Year) 28b. Time of 27, Manner of Death Certification: After 5 Pending investigation 1 Natural 2 □ No 1 Tyes within 24 hours after death. To the Funerel Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number OCME 29b. Signature and title of certifier MD May 15 2005 30. Name and address of person who completed ca of death (Item 23a) (Type, Pgnt) Penn Street Baltimore, Maryland 21201 GleenBerg 31. Date filed (Month, Day, Year) MAY 1 8 2005 32. Redistrar's Signature Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene State Registrar Amend items 1 & 29d per th/ Certificate of Death wichd/4-19-95/41 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Townsend Day 6:00 **Physician** -Towsend 2005 Humphreys May 15. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 702 Howard St. Salisbury

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) Wicomico Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Hours **Funeral** Months 10XM 2□ F 215-20-0538 Director 79 11/24/1925 Maryland Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location the Maryland 10b. County 10a State 28e-f ehow the Medical Examiner must be notified at 1 Styes 2 □ No Maryland Wicomico Salisbury Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 702 Howard St. 21801 USA. Pages 1 and 2 should be filed within 72 hours after death in nent of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural", or Items 23sury or other traumatic event, tra Medical Examiner intest. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: Army Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Automotive 11 Auto Parts Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elmer Townsend Jennie Mills 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ruth Townsend/wife 702 Howard St., Salisbury, MD 21801 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or 6/19/05 Salisbury, MD Shad Point Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Holloway Funeral Home Professional Association Holloway Funeral Home Professional Associated the death of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, appropriatory one cause on each line.

Holloway Funeral Home Professional Associated the death of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, 1 a.y, cooking to minocolor cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of) P.O. Box 68760. Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 DEctopic pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Pe 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 Yo 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA Certification: To 24 hours after death.

Funeral Director; After thielely tilled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Matural Division 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital 1 Certifying Physician. To the basis of any knowledge, death occurred at the third, date and place, and due to the cauce(s) and marrier as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29b. Signature and 30. Name and address of person who completed cause of death (Item 23a) (Type 27 100 E Carroll 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 8 2005 Registrar

		•	1 - For State of Maryland / Department	artment of Health and M rtificate of Death	ental Hygier	ZIIII	18581
	Physici /Medic		Decedent's Name (First, Middle, Last)  FANNIE ATELIA TRITAPOE		2. Date of Death Month I	Day Year 2005	3. Time of Death 1:40 A M
	Examin		4a. Facility Name (If not institution, give street and number) KLINE HOSPICE HOUSE	4b. City, Town, or Location of Death  MT . AIRY			ERICK
	Funeral Director		5. Social Security Number 6. Sex $1 - M = M$ 2 $\times F$ 7. Age (In yrs. last birthday) $1 - M = M$ $2 \times F$ 95 Yrs.	Months Davs Hours Min.	8. Date of Birth (Month, Day, Yea OCT. 23,		hplace (State or Foreign untry) MARYLAND
	the Maryland 28a-f show	tor	10a. State 10b. County 10c. City, Town or Lo	ocation KNOXVILLE			10d. Inside City Limits 1 ☐ Yes 2 🗓 No
	with the 3e or 28a	Funeral Director	10e. Street and Number 1346 WEVERTON ROAD	10f. Zip Code 21758	10g. (	Citizen of What Co	•
036	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or items 23e or 28a-f show event, the Modical Extrainer must be notified at	þ	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	ncan Indian,
21215-0036	within 72 ho iene. rthen "naturi	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation e kind of work done during most of working DO NOT use retired) SEAMSTRESS	ng	Kind of Business/	Industry
Maryland 2	2 should be filed withir and Mental Hygiene. is marked other then aumatic event, the M	To Be C	17. Father's Name (First, Middle, Last)  LAFAYETTE ALCO MAIN	18. Mother's Name	(First, Middle, Maid IE KEPHART	en Sumame)	
	1 and 2 sho Health and Iem 27 is ma		RUSSELL L. TRATAPOE JR./SON 2423	BOTELER ROAD, BROW	NSVILLE,	MARYLAND	21715
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importantis if item 27 is marked other then "natural", or items 23e or 28e-1 show any injury or other traumatic event, it e Modical Examinating the notified at any injury or other traumatic event, it e Modical Examinational Denotitied at any injury or other traumatic event.		1 & Bunal 2 □ Cremation 3 □ Hernoval from State  1 4 □ Dopation 5 □ Other (Specify)  21. Sign fure of Fineral Service, Licensee	LLE HGTS. CEM 5/25 2. Name and Address of Facility AST FINNER AT. HOME	/2005 _BR 7606 Old	National	E, MARYLAND Pike
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. Dist only one cause on each line.  Immediate Cause (Final disease or condition	ter the mode of dying, such as cardiac o			Approximate Interval Between Onset and Death
	/Medical Examiner	16	resulting in death)  Due to (or as a consequent of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	tive Heart Fa	LUCAN DI.	25/36	5 years
8760,	cate be executed physician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):				
9	ill g	Medic	JF FEMALE:				
.O. Box	that the death certifics ed by the attending pt detached for use as t	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Tetal death 35	□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	ivery Day Year
ords, P	The law requires that the site has been signed by the bage 2 should be detached.	by	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacc 1 ☐ Yes		the cause of death?
Vital Record		Completed			24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of 2 \( \square\) No
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpaties	26. Place of Death		a <b>V</b> iou - 70	. Hogpies
Division of	Attending Physic death.  ector: After this by the funeral did	atlon: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury	A Nuising Ho	ne 5 Residence 28d. Describe how in		туловрісе
Divis	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str. building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, Sta		ral Route Number,
	To the Hospitel or within 24 hours after To the Funeral Dirticompletely filled in I	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurre	ed at the time, date a	and place, and due	to the cause(s)
)	To To	Σ	29b. Signature and title of gentitier Lewin M. D.	29c. License number  2703	7 29d. [	Date signed (Month	n. Uay, Year)
Z			30. Name and address of person who completed cause of death (Item 23a) (Type, MD C ( ) 31. Date filed (Month, Day, Year)  MAY 2 ½ 2005  32. Registra's Signature	Ninde Aue	3 runswi	de 11	13 21716
	Sta Registr		MAY 2 ½ ZUU5	Sperke			

	•	1 - For State Registrar	State of M	aryland /		irtment of F tificate of		Mental H	lygiene Reg. No	Ca U U U	18582		
Physicia	an	1. Decedent's Name (First, Middle, Las Ruth McNeil THOM						2. Date of Month	Da	A	3. Time of Death		
/Medic Examin	al	4a. Facility Name (If not institution, give				4b. City, Town, o	r Location of Dea	ath May	20	County of Death			
	<u>.</u>	Washington Count	-				stown			Washingt			
Funeral Director		5. Social Security Number 6. Sec. 214-09-7199	ox 7. Ag □M 2፟Ag	95	Yrs.	If Under 1 Year Months Days	Hours Min	8. Date of (Month, Oct.	Day, Year)	Cou	place (State or Foreign intry) ryland		
and w.		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	wn or Lo	cation	-				10d. fnside City Limits		
Mary a-f sho	tor	Maryland Washin	gton		Hage	rstown				1 Tes 2			
with the a or 28 Liberio	Director	10e. Street and Number 22013 Grove Roa	d			10f. Zip Code	21742		10g. Ci	tizen of What Cou USA	untry?		
filed within 72 hours after death with the Maryland Hygiene. Hygiene, they filed within the handless or 188-f show ant, the Madical Erather for must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:	,		Vas Decedent of he f Yes, specify Cub	dispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or erto Rican, etc.)	No-	14. Race - Amer Black, White Specify: W			
permit. Pages 1 and 2 should be filed within 72 hou popartment of theath and Mental Hygiene. Important: if item 27 is marked other than "natura any injury or other traumatic event, the Madical Eginee.	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed) College (1-4or		a. Deced (Give life. L	lent's Usual Occup kind of work done OO NOT use retire	pation during most of w d)	rorking	16b. Kind of Business/Industry				
ed with ygiene her than	Com	8	0	37)	c1	erk		(E:) Alid	45- 44-74-4	statio	nary		
d be fill sontal H ced off	o Be	17. Father's Name (First, Middle, Last) Thomas Head						ame <i>(First, Mid</i> rie Simn		i Sumame)			
shoul and Me s mark	70	19a. Informant's Name/Relationship (7	Type, Print)	19	b. Mailin	ng Address (Street	and Number or I	Rural Route Nu	mber, City	or Town, State, Zi	ip Code)		
1 and 2 Health om 27 I		Osborne Thompson  20a. Method of Disposition	- son			.3 Grove		agerstov Date		aryland ocation - City or T			
Pages nent of t ant: If ite		Commetterly, crematory or other place)  **DBurial 2 Cremation 3 Removal from State  **4 Donetion 5 Other (Specify)  Rose Hill Cemetery 5/23/05 Hagerstown, Mary											
permit. Departr Importe any inje		21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 217											
Physician /Medical Examiner	ər	23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate	a. Que to (or as	d the death. Do	spi.	er the mode of dyi ryfog Abomin	Avve	tac or respirator LR Au		'L	Approximate Interval Between Onset and Death		
ficate be executed physician and strength burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	s a consequence	e of):								
	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		of pregnancy 2  Fetel deat at time of death		Ectopic pregnanc Other (specify)	y		-	23d. Date of delive Month	very Day Year		
quires that n signed build be deta	by	Part II. Other significant conditions c	ontributing to death I	but not resulting	in the u	nderlying cause gr	ven in Part I.				the cause of death?		
To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours alter death set that the Certificate has been signed by the attending to the Funeral Director. After this certificate has been signed by the attending completely liked in by the funeral director, page 2 should be detached tor use	Completed							1 🗆 Ye	utopsy erformed? s 2	prior to c death?	topsy findings available ompletion of cause of 2 □ No		
ysiciar ysiciar s certif	To Be	25. Was case referred to medical examiner?  1  Yes  2  O	Hospital: 1 ☐ fnpati	ient 22ER/C	Outpatier	nt 3 DOA Ott	200	eath <i>(Check or</i> Home 5□ P		6 ☐Other (Spec	ify)		
ding Ph h. Atter thi tuneral		COL Describe to which the second											
or Atten alter deal Director	Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of In	njury - At home, htc. (Specify)	farm, str	eet, factory, office		28f. Locatio City or	n (Street a Town, Stat	nd Number or Ru e)	ral Route Number,		
Hospita 24 hours Funeral etely tilled	edical C		ysicien: To the best niner: On the basis of and manner s	of examination a									
To the within To the compl	Me	29b. Signature and title of certifier	71			29c. Licen			29d. Da	ate signed (Month			
		30. Name and address of person who	completed cause of	death (Item 23a	(Type,	north.	8267 W/SU		12:	20	- 2005		
-2			aupus R	trar's Signature	± 1	27,149	estou,	MD 2	174	L	···		
Sta Registi		31. Date filed (Month, Day, Year) MAY 23 2	005	m B.	Sp	whe							

			For State Registrar	State of Maryland		artment of H			giene Reg. No	005	18583
:	Physici		Decedent's Name (First, Middle, La	Donald A. West	cott			2. Date of De Month	ath Day	Year 2005	3. Time of Death - 6:50 A M
	/Medic Examin		4a. Facility Name (If not institution, given Doctors Communi	re street and number)		4b. City, Town, or Lanham	Location of D			ounty of Death	orges
	Funeral Director		5. Social Security Number 6. S	Sex 7. Age (In yrs. la 1	st birthday, Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Bir (Month, Da	y, Year) 2,193	9. Birthr Cour Nebr	place (State or Foreign ntry) aska
	aryland show	Ļ	Usual Residence of Decedent  10a. State 10b. County		Town or L						10d. Inside City Limits 1 A yes 2 No
	with the Ma 1 or 28e-f	Director	10e. Street and Number	Georges		Bowie  10f. Zip Code	2071	5	10g. Citiz	en of What Coul	
36	pormit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dopertment of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Itams 23a or 28e-f show any ijury or other traumatic evant, the Medical Ext. ill with the notified at ODG.	by Funeral	2804 Botany Lar  11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1. \( \tilde{\Omega}\) Yes 2 \( \tilde{\Omega}\) No \( 195\) (If Yes, Give Year or Dates: \( 19\)	5-	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🖾 No		? (Specify Yes or No Puerto Rican, etc.)		4. Race - Americ Black, White, Specify: Whi	etc.
21215-0036	within 72 hou ene. than "natura he Medical E	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation	16a. Dece (Give life.	edent's Usual Occup e kind of work done DO NOT use retired	ation during most of d)	f working		d of Business/In	
Maryland 2	uld be filed lental Hygi rked othar lic evant, I	To Be Co	17. Father's Name (First, Middle, Las		cott			Name (First, Middle olet Moris		Gurname)	
	nd 2 should alth and Men 27 Is marke ir traumatic		19a. Informant's Name/Relationship Beverly A. West					or Rural Route Numb owie, Mary			o Code)
Baltimore,	Pages 1 annent of Heamant: If itam		20a. Method of Disposition  1 \( \begin{align*} \text{Burial} & 2 \subseteq Cremation & 3 \( \begin{align*} \text{Cremation} & 3 \)  4 \( \begin{align*} \text{Donation} & 5 \subseteq \text{Other} (Special) \)	_Hemoval from State   T _1_		osition (Name of ematory or other place Memorial		5 <b>–</b> 23–05 ns		ation - City or T	<sub>own, State</sub> Le, Maryland
Balti	permit. Departrimporta any inju		21. Signature of Funeral Service Linco	A Beal				Beall Fur Hwy., Boy			1 20715
	Physician /Medical		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused the death y one cause on each line.  a. Due to (or as a phoseque)	Soletic	nter the mode of dyir	ng, such as ca	urdiac or respiratory a	rrest,		Approximate Interval Between Onset and Death  ### WEEKS
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,092	ate be executed hysician and the burial-transit	cal	that initiated events resulting in death) Last	Due to (or as a con equ	ence of :	vone fle	lung				Tweek
.O. Box 68	death certific e attending pl ed for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	□Ectopic pregnancy □ Other (specify) _	/		2	3d. Date of deliv Month	ery Day Year
s, P	w requires that the been signed by the should be detache	by	Part II. Other significant conditions	contributing to death but not resu	liting in the	underlying cause giv	ren in Part I.				the cause of death?
al Record	The la ate has page 2	Completed					00 Plans	1 Yes	psy ormed? 2 \Begin{align*} No		opsy findings available ompletion of cause of
of Vital	S S	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death	28a. Date of Injury	ER/Outpation 28b. Time	SIIL 3 DOX	ner: 4 ☐ Nurs	ing Home 5 Res	idence 6		(y)
Division	To tha Hospital or Attanding Phwithin 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	Certification:	1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 380 Bloom of Injury - At ho	Injury me, farm, s	M 1 🗆	rk? Yes 2 ⊡ No	28f. Location	(Street and wn, State)	d Number or Rur	al Route Number,
	a Hospital of 24 hours at a Funaral Dietely filled i	ledical Ce	29a. Certifier 1 Certifying F (Check only one)	Physician: To the best of my know aminer: On the basis of examinat and manner stated.	wiedge, dea ion and/or i	ath occurred at the ti investigation, in my o	me, date and opinion, death	place, and due to the occurred at the time	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To tha within 2 To tha comple	Med	29b. Signature and title of certifier	-miD.		29c. Licens				signed (Month)	. Day, Year)
2	(5) IV	a	30. Name and address of person who	o completed cause of death (Item		e, Print)			1.0	,	
	St Regist	ate rar	ROBULT B. W. A GNEL, MA 31. Date filed (Month, Day, Year) MAY 1 9 200	22. Registrar's Signal	ture	Les					

			1 - For State Registrar	State of M	aryland / Depa		of Health a of Death	and Me		iene	105	18584
	Physici	an	1. Decedent's Name (First, Middle, Las Jewell E. Wrig		ie				2. Date of Death	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give			4b. City, Tow	m, or Location of	of Death	May 13		005	4:00 A M
	Examin	CI	Prince Georges H	ospital		Chev				Prin	ce Geo	orges
	Funeral Director		260-42-1438	ex 7. Ag ☐ M 2. 25 F	99 (In yrs. last birthday) 77 Yrs.	If Under 1 You Months Da	ear If Under ays Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, 12/29/1	927	9. Births Coul Ge 01	place (State or Foreign ntry) rgia
	/land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo						1	10d. Inside City Limits
	a-f sh	ctor	Maryland Prince	Georges	Landov	er						1K∐Yes 2 No
	vith the	Dire	10e. Street and Number			10f. Zip Coo			10		of What Coul	ntry?
	ns 23c	erai	2700 Orchid Summ	12. Was Decedent	Ever in U.S. 13,	2078 Was Decedent		ain? (Spec	cifv Yes or No-	USA 14. R	Race - Americ	can Indian,
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28e-1 show other traumatic event, the Medical Examiner must be inclifted at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Forces?  1  Yes 2 X  If Yes, Give Year or Dates:	No	If Yes, specify (	of Hispanic Orig Cuban, Mexican No Specify:	, Puèrto F	Rican, etc.)		Black, White,	
21215-0036	72 hor	Completed	15. Decedent's Ed (Specify only highest gra	ducation ide completed)	16a. Dece	dent's Usual Oo	ccupation one during most	t of workin	na	16b. Kind of	Business/In	dustry
121	within ane. than	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)		using M			C + + + 1	. Serv:	iaa
d 2	filed Hygie Dather I		17. Father's Name (First, Middle, Last)		DISC	riet no			(First, Middle, M			ice
/lan	2 should be filed within n and Mental Hygiene. is marked other than "raumatic event, the Men	To Be	George Wright		a Pea	ar1						
Maryland	id 2 sho th and 1 27 is me traume		19a. Informant's Name/Relationship ( Yvonne McKenzie -			Route Number, Landove			Code)			
re,	s 1 and 2 of Health item 27 i		20a. Method of Disposition		20b. Place of Dispo	osition (Name o		Da	ate 2	20c. Locatio	n - City or To	own, State
imo	Page ment o ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify)		Fort Lin	coln Ce	metery		1/2005	Brent	wood,	MD
Baltimore,	permit. Pages 1 a Department of Hei Important: If item any injury or othe		21. Signature of Funeral Service Licer Myelin T. Welen		2:	2. Name and Ad 3401 B	ddress of Facilit Ladensb	For urg l	t Lincol Rd; Brei	ln FH	1 MD 2	0722
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	d the death. Do not en	ter the mode of	dying, such as	cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death
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	/Medical Examiner		Toolang in dollar,		a consequence of): tated Stat	e						
	WHIM	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	a consequence of):							
	ecuted ind transii	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	atic Cance	r						
8760,	be executed sician and burial-transit	ai Ey	resulting in death) Last		a consequence of): c Depletio	n						
9	ifficate I g physi as the b	ledic		d		-						
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	⊒Ectopic pregn ⊒ Other (s <i>pecif</i> )					Date of delive Month	ery Day Year
9	ires that signed b d be deta	by	Part II. Other significant conditions of	ontributing to death b	out not resulting in the u	nderlying cause	e given in Part I.		23e. Did tob	4		he cause of death?
Records,	w requir been si should	ietec							24a. Was ar			ppsy findings available
Re	The lay	Completed							autopsy	y	prior to co death?	mpletion of cause of 2□ No
Vital		BeC	25. Was case referred to medical examiner?				26. Place	of Death	(Check only one		1 1 103	2010
of V	S S	은	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatio					ne 5 Reside			y)
	ding After fune	tion	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ury 28b. Time o Injury		Injury at Work? 1 ☐ Yes 2 ☐ i		8d. Describe ho	w injury occ	curred	
Division	or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not b	9 28e. Place of In	jury - At home, farm, st tc. (Specify)				8f. Location (Str City or Town	reet and Nu	m <i>ber or Rura</i>	al Route Number,
Ö	itaf or A											
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edicai	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	ysician: To the best niner: On the basis of and manner st	of my knowledge, deat of examination and/or in ated.	h occurred at the vestigation, in r	ne time, date and my opinion, deal	d place, a th occurre	nd due to the ca d at the time, da	iuse(s) and ite and plac	manner as s e, and due to	tated. o the cause(s)
	To the To the comp	M	29b. Signature and title of certifier				cense number		25	1	ned (Month,	Day, Year)
0	(1)		gullow	0)1	1		7577	7		5/13	100	<b>S</b>
1	(10)		30. Name and address of person who	hoell MI)	3001 Hosp	oital D	rive Cl	hever	ly, MD	20785		
	Sta		31. Date filed (Month, Day, Year)  MAY 1 9 200	Registr	rar's Signature	100	,					
	Registi	di	MMI T 9 500	- Julius	o de lega	- Carl						

ADH		
PAUL	WINESTOCK,	SR.
05-32	266	

	,		ate of Maryland / Dep		d Mental Hygi	•	18585
Physici /Medi		1. Decedent's Name (First, Middle, Last) Paul Winestock	s, Sr.		2. Date of Death Month MAY 1	.0, 2005	3. Time of Death 2223 P
Examir Funeral Director	ner	4a. Facility Name (If not institution, give stree PRINCE GEORGES HOSP  5. Social Security Number 577-48-0152  1	TAL 7. Age (In yrs. last birthda			PRINCE GEO  9. Birth  Paril 1936  Value  4c. County of Death	
he Maryiand 28e-f show	Director	Usual Residence of Decedent  10a. State 10b. County  DC  10e. Street and Number	10c. City, Town or	Was	shington		10d. Inside City Limit
should be filed within 72 hours after death with the Maryland and Mental Hygiene. The Views 23s or 28e-f show marked other then "natural", or liews 23s or 28e-f show matic event, the Medical Examinar must be notified at	by Funerai	212 Wayne P1ac  11. Marital Status  1 □ Never Married 2 Married  11. Marital Status		10f. Zip Code  20032  I. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P		United St  14. Race - Ameri Black, White,  Specify:	tates can Indian,
ithin 72 ho	Completed	15. Decedent's Educatio (Specify only highest grade cor Elementary/Secondary (0-12)	n 16a. Dec (Gin life	edent's Usual Occupation ve kind of work done during most of DO NOT use retired)	working 10	6b. Kind of Business/Ir	
a la b y	Be	17. Father's Name (First, Middle, Last)		Cook	Name (First, Middle, Ma	Private	e
9 10 10	2	John Winest  19a. Informant's Name/Relationship (Type, I	Print) 19b. Ma	iling Address (Street and Number o	r Rural Route Number,		p Code)
ages 1 and 2 nt of Health :: If item 27 or other tre		Delores Mayfield  20a. Method of Disposition 1 Delores Mayfield 2 Cremation 3 Remo	val from State 20b. Place of Dis	7 Central Ave.,	Date 20	DC 20018  Oc. Location - City or To	own, State
permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other 20058.	-	4 □ Conation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee		22. Name and Address of Facility	5/18/2005 Stewart Fu		
Physician /Medical Examiner		23a. Part1 Enter the disease, or complication shoot of heart failure. List only one call immediate cause (Final disease or condition resulting in death)	iuse on each line.	4001 Benning Ro	diac or respiratory arres	str., DC 200	Approximate Interval Between Onset and Death
te be executed ysician and e burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a consequence of):  Due to (or as a consequence of):				
The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	in the past 12 months?		☐Ectopic pregnancy ☐ Other (specify)		23d. Date of deliv Month	ery Day Year
w requires that been signed b should be deta	by	Part II. Other significant conditions contribu	iting to death but not resulting in the	underlying cause given in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to t	he cause of death?
	Completed				24a. Was an autopsy performs	prior to co	opsy findings availab impletion of cause of
rnysician: this certific al director,	To Be	Was case referred to medical examiner?     IXYes 2 □ No	tal: 1 Inpatient 2 ER/Outpati	ent X DOA Other: 4 Nursir	Death (Check only one)  ng Home 5 Residen  28d. Describe how	ce 6 Other (Special	(y)
To the Hospitel or Attending within 24 hours atter death.  To the Funerel Director: After completely filled in by the funer	Certification:	2 Accident investigation	Be. Place of Injury - At home, farm, building, etc. (Specify)	O'Y 1 Yes 2 No	28f. Location (Stre	ect Sh et and Number or Rura State) / ()	1
To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	Medical (	(Check only 2 Nedical Examiner:	n: To the best of my knowledge, de On the basis of examination and/or and manner stated.	ath occurred at the time, date and p investigation, in my opinion, death o	lace, and due to the cau	se(s) and manner as s e and place, and due to	tated. o the cause(s)
withi	×	29b. Signature and title of certifier	Polle ms	29c. License number OCME	N	1. Date signed (Month, MAY 11, 20	005
(4)		30. Name and address of person who comple	eted cause ordeath (Item 23a) (Type	fil Penn Street	Baltimore	, Maryland	21201
Sta		31. Date filed (Month, Day, Year)  MAY 1 9 2005	32 Registrar's Signature	·			

			1 - For State Registrar		State o	f Marylan		artment tificate				lental Hy	/gien	21115	1858	36
	Physici	an	1. Decedent's Name (First, Joan Martina									2. Date of D Month	Da		3. Time of De	
	/Medic Examin		4a. Facility Name (If not inst			mber)		4b. City, 1	Town, or	Location	of Death	May	16,	2005 c. County of Deat	9:45 <sup>p</sup>	
			Montgomery	<del></del>					ckv:					Montgor		
	Funeral		5. Social Security Number 578-52-1774	6. Se	x ]M 2. ∑X0F	7. Age (In yrs.	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of B	ay, Year		hplace (State or Fo nuntry)	
	Director		Usual Residence of Decede	nt		66						Aug. I	/, <u>1</u>	.938  Wash	nington,	DC
	arylan show	7	10a. State 10b. Co		7		ty, Town or Lo								10d. Inside City L	_
	the M	ecto	Virginia No  10e. Street and Number	r chum	berland	1	Burg	10f. Zip	Code				10g C	itizen of What Co		
	3a or	io ie	800 Old Gl	ebe Po	oint Ro	oad			2432				.og. o	USA	-	
	ams 2	Funeral Director	11. Marital Status		12. Was Dec Armed Fo	edent Ever in U	.S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Spo	ecify Yes or N Rican, etc.)	0-	14. Race - Ame Black, Whit		
36	hours after death with the Maryland tural; or Itams 23s or 28s-f show at Examera must be collined at	by Fu	1 Never Married 2 ☐ 3 ☐ Widowed 4X Div		1 ☐ Yes If Yes, Gi Year or D	ve		1 ☐ Yes 2		Specify:				Specify: Wh		
21215-0036	2 hour	ted k	15. Dec	edent's Edu	cation	/at65.	16a. Dece	dent's Usua	I Occupa	ition			16b. l	Kind of Business/	Industry	
215	thin 7. re. ren "n	Completed	(Specify only a Elementary/Secondary (0		College (	1-4or 5+)		kind of wor DO NOT us				ing				
7	iled w tygler ther th		12 17. Father's Name (First, M.	ddle last)			Pı	rogram	n Mar			e (First, Middle			vernment	-
Maryland	ld be f ental h ked of	To Be	Bernard Jam		oson							a Wilk		ŕ		
ary	and M a mar	-	19a. Informant's Name/Rela				19b. Mailir	ng Address	(Street a					or Town, State, 2	Zip Code)	
	and 2 ealth m 27 I		Jeannie Fin	negan,	/ Daugh					eaf D					yland 21	.029
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 2718 marked other than "natural", or Items 238 or 28a-f show any injury or parer traumatic avant, Ite Medical Examere must be confilled at once.		20a. Method of Disposition  Burial 2 Crema			01-1-	Place of Dispo cemetery, crei e of Hea	natory`or ot	her place		May			_ocation - City or		
Itin	artmer ortant injury	l	*4 □Donation 5 □ Oth		- A	040					20			ver Spri me Inc.	ng, Mary	lan
B	Dep Imp		by best	4/5	Luke	-									,MD 2090	1
			23a. Part Enter the disea shock, or heart failure	e, or comp List only o	lications that ne cause on	caused the deat each line.	th. Do not ent	er the mode	e of dying	g, such as	cardiac	or respiratory	arrest,		Approximate Interval Betwee Onset and Dea	∃n
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	_	a	astatic		n Can	cer						Oliset and Dea	.01
R	Examiner		,,	- (	Due to	(or as a consec	quence of):									
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	J	b. Due to	(or as a consec	quence of):								-	
	ecuted and transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last	1	c	/										
8760,	cate be executed ohysician and the burial-transit			U		(or as a consec	(uerice oi).									
9	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Medical			0								- 1			
Вох	eath certific attending pl for use as t	an/N	IF FEMALE: 23b. Was decedent pregna in the past 12 months'	nı		tcome of pregnation		Ectopic pre	egnancy				1	23d. Date of del Month	ivery Day Year	,
0.	he dea the al	ysici	1 ☐ Yes 2 🏖 No 9 ☐ Unknown		4□Preg 9□Unkr	nant at time of o	death 5	Other (spe	ecify)	_				141011411	Day Tour	
۵.	es that the de igned by the be detached	by Ph	Part II. Other significant co	nditions co	ntributing to c	leath but not res	sulting in the u	nderlying ca	ause give	n in Part I		23e. Did	tobacco	use contribute to	the cause of deat	h?
rds	- S D							_	_			10	Yes 2	2. 2 No 3 □ Pr	obably 4 Unki	nown
Vital Records,	law as b 2 sl	Completed										24a. Wa auto	psy	prior to a	topsy findings ava- completion of caus	
al R	Th ate pag	Соп										perl 1 ☐ Yes	ormed? 2⊠N	death? o 1 ☐ Yes	2□ No	
Vits	Physician: Th this certificate ral director, paç	o Be	25. Was case referred to m examiner?  1 \( \text{Yes} \) 2\( \text{X} \) No	-	Hospital:	Inpatient 2	TER/Outrobe	nt 3 DO	Othe			Check only		C [3]Oth /C	city) Hospic	
1 of		$\vdash$	27. Manner of Death		28a. Date		28b. Time o		Bc. Injury Work	4 🗆 140		28d. Describe			diy) HOSPIC	е
sior	if 를 <sup>다</sup> 를 다	atlo	2 Accident	ending vestigation		nii, Day Your,	injury	М		Yes 2□						
Division	or At or At Direct or by	ertification:		ould not be etermined	289. Plac	e of Injury - At h ling, etc. (Speci		eet, factory	, office			28f. Location City or To	(Street a own, Stat	ınd Number or Ru te)	ıral Route Number,	'
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	O	29a. Certifier 1 Ce	rtifying Phy	sician: To th	e best of my kno	owledge, deat	n occurred a	at the tim	e, date an	id place,	and due to the	cause(s	s) and manner as	stated.	
	the Ho nin 24 the Fu	ledical	one)	Jical Exam		nasis of examina nner stated.	ation and/or in				ith occurr	ed at the time		nd place, and due		
	with To	Σ	29b. Signature and title of c	artitier	4/	^		290	. License	number	10		29d. Da	ate signed (Monti	n, Day, Year)	
	2		30. Name and addr is of p	erson who c	ompleted cau	se of death (Ite	m 23a) (Tvne	Print)	7	177	+8		5	11741	07	-
			Charles Ha					-	ill	Road	, Ro	ckville	, Mai	ryland 2	0855	
	Sta		31. Date filed (Month, Day,		32. 1	Registrar's Signa	ature	W.								
	Registi	al	MAY 1 8	, 2003	Down	CO SO.	1									

Irvin Wesley W 05-03502	Vil	liams Please Type or Print in Black indelible ink, Ensure All amend /urpend item/1,23,27,26 f, pendi,6345,77/05 TT State of Maryland / Department of Health and M	l Copies A	re Legible.	
crn	•	State of Maryland / Department of Health and M		ene 005	18587
Physicia	n	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
/Medica	al -	IRVIN WESLEY WILLIAMS, III  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	May	20 2005 4c. County of Death	5:35 P <sup>M</sup>
Examine	1	Carroll Hospital Center Westminster		Carrol1	
Funeral Director		5. Social Security Number  219-71-7018    Sex   1	8. Date of Birth (Month, Day, Y 3 / 19 / 2)	'ear) Cou	place (State or Foreign ntry) YLAND
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 is marked other than "netural", or items 23a or 28a-f show treumatic event, the Mudical Exercities must be rediffed at	ctor	10a. State         10b. County         10c. City, Town or Location           MD         CARROLL         WESTMINSTER			10d. Inside City Limits 1 ☐ Yes 🏖 No
with the nor 28	Director	10e. Street and Number 10f. Zip Code		. Citizen of What Cou	ntry?
leath v	Funerai	3111 SALEM BOTTOM RD. 21157  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe		USA 14. Race · Amer	can Indian.
21215-0036 d within 72 hours after or sethan "netural; or iter	کر ا	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ☑ Never Married 2 ☐ Marned 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	Rican, etc.)	Black, White	etc.
15-0	etec	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of workii life. DO NOT use retired)	ng 16	b. Kind of Business/Ir	ndustry
212 3 withli Jiene. Trihan	Completed	Elementary/Secondary (0-12) College (1-4or 5+) NONE		NONE	
Maryland (1) do 2 should be filed ith and Mental Hyg 77 Is marked othe treumatic event.	To Be C	17. Father's Name (First, Middle, Last)  MARLIN ALFRED WILLIAMS  18. Mother's Name LISA I	(First, Middle, Ma FAYE HA		
Aary 2 sho 1 and h 1 s ma reuma		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rura			
s 1 and 2 if Health liem 27 other tre			-	C. Location - City or T	
Baltimore, I permit. Pages 1 and Department of Healt Important: If Item 2 any Injury or other 2006.		1 X Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  DEER PARK CEMETERY 5/25		MALLWOOD	
smit. spartm sports ny inju	Ì	21. Signature of Funeral Service Licensee 22. Name and Address of Facilin F LE	CHER F	UNERAL HO	OME
ш «ашы	-	254 E. MAIN ST., V  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or			
Pnysician /Medical Examiner		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   Sudden Uexplained Death in Infancy  Due to (or as a consequence of):	Tiespiratory arrest		Approximate Interval Between Onset and Death
pe iii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Observed or injury.			
68760, ifficate be executed g physicien end as the burial-transit	dicai Examine	c. Due to (or as a consequence of):  d.			
O. Box (  De death certified the attending t	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown		23d. Date of deliv Month	ery Day Year
ds, P.(	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to t	he cause of death?
Division of Vital Records, or Attending Physician: The law requires to after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be contact.	Completed		24a. Was an autopsy performed	d? prior to co	opsy findings available impletion of cause of
Vital Filclen: The certificate rector, pag	Bec	25. Was case referred to medical examiner? 26. Place of Death		140 141 103	20110
Of V Physic this ce al dire	9	1 X Yes 2 No Hospital: 1 Inpatient 2X ER/Outpatient 3 DOA Other: 4 Nursing Hom		ce 6 ☐Other (Specia	(y)
on oding I	tion	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  1 Natural 5 Pending 4:48 P M 1 Yes 2 No	28d. Describe how	injury occurred	
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: Alte completely filled in by the funeral process.	Certification;	3 ☐ Suicide 4 ☐ Homicide  Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	unk 281. Location (Stree City or Town, S		al Route Number, <b>em Botton Rd</b>
To the Hospitel or within 24 hours at To the Funerel D completely filled in	edical	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, a 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	ind due to the caus	se(s) and manner as s	stated. the cause(s)
To the within to the compile	ĕ	29b. Signature and title of certifier 29c. License number	29d.	. Date signed (Month,	Day, Year)
MIL		Yanteh Southell, Nes OCME	Ma	y 21, 2005	5
0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Pamelu E. Southell, MD. 111 Penn Street	Baltim	ore, Maryl	and 21201
State Registra	- 1	31. Date filed (Month, Day, Year)  32. Registrar's Signature  MAY 2 5 2005			

			State of Maryland / Department of Health State of Maryland / Department of Health 1 - For Amend Items 25,27,28a-f per ME GRADO Dealth Certificate of Dealth Certificate of Dealth 1	and Mental Hy	giene 0 5	18588
	Physici /Medic Examin	al	1 M 2 Tar Months Days Hour	der 24 Hrs. 8. Date of Bin (Month, Da	4c. County of Deal	hplace (State of Breign
	Director Mou		Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Location	April	12,14 Mar	yland  10d. Inside City Limits
	or 28a-1 s	Director	Maryland Wicomico Fruitland  10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	1 ☑ Yes 2 □ No untry?
036	4 within 72 hours after death with the Maryland liene. r then "natural", or Itams 23a or 28a-f show It to Medical Examinat mest be muitlied at	by Funeral	219 Morris St   21826		Specify:	
21215-0036	d within jiene. r than "	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 1 2  15a. Decedent's Usual Occupation (Give kind of work done during m life. DO NOT use retired)  Homemaker	nost of working	16b. Kind of Business/	Industry
Maryland	Mental Mental arked o	To Be (	17. Father's Name (First, Middle, Last)  Porter Deal  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Num		Da	ashiell
Baltimore, Ma	permit. Pages 1 and 2 sho Department of Health and Importent: If item 27 Is m any injury or othar traum once.		Esther P. Bailey-Daughter 12001 Lusby Ln, 1  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  1 Calvary Ch. Cem  21. Signature of Funeral Service Licensee	Brandywine Date 5/21/05	MD 20613 20c. Location - City or	Town, State
	Physician /Medical Examiner		23a. Part1. Enter the disease, or communitations that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	as cardiac or respiratory ar	Aquasco rest,	Approximate Interval Between Onset and Death
8760,	ate be executed hysician and he buriat-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Carter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):	ICAI N APPROVED BY MEDIC	THE EXAMINER	
O. Box 6	The law requires that the death certificate tte has been signed by the attending phys age 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknown   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   5   Other (specify)	Jewil.	23d. Date of deli Month	very Day Year
rds, P	w requires that been signed b should be deta	d by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pal  THEN SUNDIC CANDIO VAULA CASE		obacco use contribute to es 2 <b>En</b> o 3 Pro	the cause of death?
Vital Records,		Complete		24a. Was autop perfor 1 \( \text{Yes} \)	sy prior to d	topsy findings available completion of cause of
Division of Vita	Attending Physication.  death.  ctor: After this in the funeral distribution.	ertification: To Be	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other.  27. Manner of Death 1 Netwal 5 Pending investigation 3 Suicide 6 Could not be determined 5 Suicide 6 Sea Place of Injury - At home, farm, street, factory, office	XNo Probab.  28d. Describe h  Probab.  28f. Location (S	ience 6 Other (Speciow injury occurred  le fall  Street and Number or Ru	
ĺΩ	Hospital or ta hours afte Funaral Dir tely filled in I	dical Cert	29a. Certifier (Check only  Madical Examiner: On the basis of examination and/or investigation, in my opinion, december 1.2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, december 1.2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, december 1.2 Madical Examiner: On the basis of examination and/or investigation.	and place, and due to the d	rratts Road	stated.
)	To the within 2 To tha complet	Med	one) and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signed (Month	Day, Year)
1	<b>3</b> 5	te.	30, Name and address of person who completed cause of death (Item 23a) (Type, Print)  The American State of the State of	1 # 18 FT.	Washing	W NO 2074 4
	Registr		31. Date filed (Month, Pay Year) 9 2005 32. Refistrar's Signature			

			For State Registrar			tate of N	Marylar				lealth and	d Mental H	ygiene Reg. No.2	005	185	8
Г	Physici	an	1. Decedent's Name			ION.						2. Date of I Month <b>MAY</b>	Death $^{ extstyle  extst$	Year	3. Time of De	
	/Medic Examir		EMMA LINE 4a. Facility Name (				er)		4b. Ci	ty, Town, o	r Location of De			2005 cunty of Deatl		A
1	LXuiiii	*	CHARLES COL	UNIY NUR	SING &	REHABIL	TATIO	CENTE		PLAT			СН	ARLES		
	Funeral Director		5. Social Security N 220-50-95		6. Sex 1 ☐ M		Age (In yrs.	last birthday Yrs.	/) If Und Month	der 1 Year Is Days	If Under 24 H		Day, Year)	Co	nplace (State or F untry) <b>LAND</b>	ore
	<u> </u>		Usual Residence of	Decedent								JAN JI	1900	LHIVI		_
	72 hours after death with the Maryland natural', or Items 23e or 28e-f ehow diest Examinet must be rediffed at	_	10a. State	10b. County				ty, Town or I							10d. Inside City I	
	he M	Funeral Director	MD 10e. Street and Nu	CHARI	LES		NA	NJEMO		T. O. I.			40. 000			<b>n</b> .
	with the or 3	급	10726 GE		JE HAT	T. PLAC	ידי		10r.	Zip Code <b>206</b> 0	52		-	n of What Co	•	
	leath ns 23	eral	11, Marital Status	THOENA		Vas Decede		.S. 13	. Was De			(Specify Yes or		Race - Ame		
(0	or Iter	Fun	1 Never Marr	ried 2 Mar	l A	Armed Force ☐ Yes 2 f Yes, Give	s?					(Specify Yes or lerto Rican, etc.)		Black, White		
93	ral', o	l by	DewobiW <b>X</b> €	4 ☐ Divorced	4	f Yes, Give 4 Year or Date:	S:		1 ∐ Yes	2 <b>X</b> □ No	Specify:		S	pecify:	BLACK	
21215-0036	□ 38	Completed		15. Deceder cify only highe	st grade cor	mpleted)		(Giv	e kind of t	sual Occup work done use retire	during most of	working	16b. Kind	of Business/I	Industry	
212	yene.	mo	Elementary/Seco	ondary (0-12)		College (1-4c	or 5+)		MAKER		,		PRTV	ATE		
b	e filed Il Hygi other vent, Il	Be C	17. Father's Name	(First, Middle,	Last)			TIOTIL	MIKLI		18. Mother's i	Name (First, Midd				_
Maryland	should be tind Mental I	ToE	AMOS GAI	NES							ROSA	JOHNSON	GAINES			
lan	2 sho and I is me		19a. Informant's N			,		19b. Mai	ling Addre	ess (Street	and Number or	Rural Route Nun	nber, City or T	own, State, Z	(ip Code)	
	is 1 and 3 of Health item 27 other tra		CYNTHIA		GRANDD	AUGHTE				TH DR	IVE, IN	DIAN HEA				
Baltimore,	Page nent o ant: If ury or		20a. Method of Dis 1 XBurial 2 4 Donation	☐ Cremation	3 □Remo	val from Sta	te	Place of Disponentery, cr	ematory o	r other pla		Z 21,200		tion - City or T		
Balt	permit. Departr Importa		21 Snature of Fu LYD	IA C. T	Stille.	ON JOH	INSON		ZZ. Name THORN 3439	and Addre	SS OF FACILITY FUNERAL NGSTON 1	HOME, P ROAD, IN	.A.	EAD MI	20640	
	*		23a. Part1. Enter t	the disease, o	r complication	ons that caus	sed the deat	h. Do not e	nter the m	ode of dyir	ng, such as card	liac or respiratory	arrest,	, , , , , , , , , , , , , , , , , , ,	Approximate Interval Between	en
	Physician /Medical Examiner		Immediate Cause disease or condition resulting in death)	(Final	( a	Th		pocyto	pen	ia.					Onset and Dea	
	_	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	quentially list conditions, ny, leading to immediate use. Enter Undertying use (Disease or injury trinitated events c										_		
8760,	icate be executed physician and s the burial-transit	cal	resulting in death)	Last	d	Due to (or	as a consec	uence of):								
P.O. Box 6	ath certif	Physician/Med	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 0 9 ☐ Unknown	nonths? ☐No		f yes, outcon 1□Live birth 4□Pregnant 9□Unknown	2 ☐ Feta at time of c	I death 3	□Ectopic	pregnancy (specify)	4		230	d. Date of deli	very Day Yea	ır
	ires that the de signed by the a i be detached f	by	Part II. Other signi	ficant conditi	ions contribu	uting to death	but not res	sulting in the	underlying	g cause giv	ren in Part I.		d tobacco use		the cause of deal	
Records,	w requir been si should	Completed												<u> </u>		
3ec	has has 39 2 s	mpl										24a. Wi	topsy rformed?	24b. Were aut prior to c death?	topsy findings ava completion of caus	ıla e
a			05.114									1 ☐ Yes	2 No	1 🗆 Yes	2 🗆 No	
Vital		o Be	25. Was case reference examiner?		Hosp	ital:	ationt OF	LEB/Out-ati	20	Ott		Death (Check onf		7011 10		_
of	<b>윤</b> 등 등	on: To	27. Manner of Deal	th	2	8a. Date of In (Month, I		ER/Outpati 28b. Time Injury	of	28c. Inju	40 Nursin	g Home 5 ☐ Re 28d. Describ	e how injury of		eify)	
Sio	r Attending er death. rector: After by the fune	catic	2 Accident	5 ☐ Pendi invest 6 ☐ Could	igation			,,	М		Yes 2 □ No					
Division	s after d	Certification:	4 Homicide	deterr		8e. Place of buil <b>din</b> g,	Injury - At h etc. (Special	ome, farm, s fy)	treet, fact	ory, office		28f. Location City or 7	(Street and I Town, State)	Number or Ru	ral Route Numbei	,
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical (	29a. Certifier (Check only one)	1 Certifyi 2 Medical	Exeminer:	on: To the be On the basis and manner	s of examina	owiedge, dea ation and/or	ath occurre investigati	ed at the til on, in my c	me, date and pla pinion, death o	ace, and due to the	ne cause(s) ar e, date and pl	nd manner as ace, and due	stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and	d title of certifie	pr 1	0,			2	29c. Licens		C		signed (Month		
			<b>&gt;</b> /	NY	rul	el m	0			DS	228	7	5	18/0	2 0	

DHMH 17 Rev 1/2001

State Registrar 10 ST. PATRICK'S DRIVE, SUITE 404, WALDORF, MARYLAND 20603

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NALIN MATHUR, M.D.

			State of Maryland / Department of Health and Certificate of Death		2005 1000
			1. Decedent's Name (First, Middle, Last)	2. Date of Deat	n 3. Time of Death
	Physicia			Month	Day Year
	/Medic	al -	DONALD HALE ZITTLE  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De	1.1/.1.1	19 2005 12:20 P <sup>M</sup>
	Examin	er			WASHINGTON
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	rs. 8 Date of Birth	9. Birthplace (State or Foreign
	Funeral Director		214-28-5039   1\(\mathbb{M}\) M 2\(\mathbb{F}\)   72   Yrs.   Months Days Hours Mi	in. (Month, Day, JUNE 20,	
			Usual Residence of Decedent	00112 20,	
	how		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	insering	cto	MARYLAND WASHINGTON HAGERSTOWN		
	or 28	Director	10e. Street and Number 10f. Zip Code	11	og. Citizen of What Country?
	ath w	ra .	9816 SHARPSBURG PIKE 21740	(O	U.S.A.
	tems tems	Funeral	11. Maritat Status  12. Was Decedent Ever in U.S. Amed Forces?  1 □ Never Married 2 □ Married  1 ☒ Yes 2 □ No 1953-	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	hours after death with the Maryland tural; or Items 23a or 28a-f show at Evanier must be notified at	by F	1 □ Never Married 2 □ Married 1 ☒ Yes 2 □ No 1953 − 1 □ Yes 2 ☒ No Specify: 1 □ Yes 2 ☒ No Specify:		Specify: WHITE
8	hour tural		15 Decedent's Education 16a. Decedent's Usuat Occupation		16b. Kind of Business/Industry
15	within 72 ene. then "nat	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12)  Coltege (1-4or 5+)  (Give kind of work done during most of wife. DO NOT use retired)	working	
212	d withi	Completed	5 SHEET METAL ASSEMBLE	ER 1	EQUIPMENT MANUFACTURE
b	be filed within 72 hours ital Hygiene. Id other then "natural", event, Ire Medical Exa	e	The factor of th	Name (First, Middle, M	· ·
Maryland 21215-0036		ToE		RENE FAUL	
lan	and and is m		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or		
	1 and 2 Health tem 27 other tra		DONNA J. FOGLE/DAUGHTER 954 MT. AETNA ROAD,  20a Method of Disposition (Name of		N MARYLAND 21740
0	ges 1 ar it of Hea if item or othe		1 █ Burial 2 □ Cremation 3 □ Removal from State		,
Baltimore,	nit. Pa partmen cortant: injury ie.		4 □ Donation 5 □ Other (Specify)  BEAVER CREEK CEMETERY 05/  21. Sign sture of Puddal Servi > Licensee		
Bal	permit. Pages Department of I Important: If ite any injury or of		21. Signiture of Purofial Servic Licentee Paul M. Dean 22. Name and Address of Facility BAST FUNERAL HOME	•	d National Pike ro, Maryland 21713
	_		23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.		
	Pnysician	2 10	Immediate Cause (Finat	212	Onset and Death
	/Medical		disease or condition resulting in death)  a Due to (or a consequence of):		3 100 01111
	Examiner		Sequentially list conditions, b. lung cancer		4 years
	D =	Iner	Due to [or as a consequent of ]: cause. Enter Underlying Cause (Disease or injury		Q
	ecute and trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):		
8760,	cian a	Ë	Due to (or as a consequence of).		
87	The law requires that the death certificate be executed ite has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai	d		
9 x	death certific attending pl d for use as t	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
Box	that the death cer ed by the attendir detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No  1 Yes 2 No  1 Other (specify)		Month Day Year
O.	at the d by the tached	isk	9 Unknown		
٦,	w requires that s been signed b should be deta	by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tot	pacco use contribute to the cause of death?
rds	quire; nn sig uld ba	pe pe		_ XY	es 2 No 3 Probably 4 Unknown
Records,	s bee	Completed		24a. Was a	
Re	sician; The lav certificate has irector, page 2 :	E O		perform	med? death?
Vital		a		Death (Check only on	
f V	D 0	To B	examiner? 1 Yes 2 Xe  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursin	g Home 5 Reside	ence 6 Other (Specify)
n of	ding Pt. After th		28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe ho	ow injury occurred
Sio	Attending r death. ector: After by the fune	catio	2 Accident investigation M 1 Yes 2 No	001 1	Series of March 2012 County Street
Division	or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town	reet and Number or Rural Route Number, n, State)
0	pital ours a eral C	S	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pl	ace and due to the c	ause(s) and manner as stated.
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death o and manner stated.		
	To th within To th comp	Me	29b. Signature and title of certifier 29c. License number	2	9d. Date signed (Month, Day, Year)
			Hud Hann dan Dubl	173	May 20, 2005
12	11 ,		30 Name and address of person who completed cause of death (ttem 23a) (Type, Print)		21740
4	11-15+1		tling tlamadan, MD; 1130 OPAL	- (1,1)	rugerstown, mis
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  MAY 2 0 2005  32. Registrar's Signature		7
	9.00		KIRCUM N. P. BECKER		

ORIGINAL

		-	For State Registrar	State of Mar	-	partment of F ertificate of i		-	ne 005	18591
	Discription		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		ALICE DEVI	EDA AI	LLISON			MAY 28		7:17 A M
	Examin	er	4a. Facility Name (If not institution, give s			4b. City, Town, o	Location of Death		4c. County of Dea	th
		*	FREDERICK MEMO			FREDER	RICK If Under 24 Hrs.	O Date of Birth	FREDER	
г	Funeral Director		5. Social Security Number 6. Sex 10	M 257 F	'In yrs. last birthd 76 Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Day, ) Nov 24,	ear) C	thplace (State or Foreign ountry) ryland
	D		Usual Residence of Decedent							
	show	2	10a. State 10b. County	1	loc. City, Town or					10d. Inside City Limits 1 ☐ Yes 2√☐ No
	the M	Director	MD Frederic  10e. Street and Number	k	Fre	derick		100	J. Citizen of What C	AL
	with Se or	D	826 Chadwick Circ	1 م			21701	100	USA	ountry:
	death	Funeral		2. Was Decedent Ev	er in U.S.	Was Decedent of H     If Yes, specify Cuba		ecify Yes or No-	14. Race - Am	
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or Hems 23e or 28e-f show that the Madical Exeminating the natified at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:	Hican, etc.)	Specify: T	white
5-0	72 ho	Completed	15. Decedent's Educ (Specify only highest grade		(G	cedent's Usual Occup	during most of work	sing 16	Sb. Kind of Business	/Industry
121	within	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		e. DO NOT use retired	•		. 1	•
2	filed v Hygie other i	CO	12 17. Father's Name (First, Middle, Last)	0	as	sembly per		e (First, Middle, Ma	electron	nics .
an	lid be lental rked c	To Be	Homer Troy Bolya	rd			Audrey	Louise Mo	Donald	
ary	and N		19a. Informant's Name/Relationship (Type			ailing Address (Street			•	
Σ	and 2 ealth m 27 i		Stephen Allison/	son		E. South				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28e-1 show any njury or other treumatic event, It e Marical Examinating the nutilised at ODGs.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☑ Donation 5 ☐ Other (Specify)	/	20b. Place of Di cemetery,	sposition (Name of crematory or other plac		Date 20	c. Location - City of	Town, State
Balt	permit, Dep rtr Importa any nji		21. Sig ature of Funeral Service Licenses	Nade, Dir	ctor	State Anat Baltimore,	ss of Facility Omy Board MD 2120	1 655 W. 1	Baltimore	Street
			23a. Part Enter the disease, or compli shock or heart failure. List only or	cations that caused the cause on each line	ne death. Do not	enter the mode of dyir	ig, such as cardiac	or respiratory arres	it,	Approximate Interval Between
П	Physician		Immediate Cause (Final disease or condition	Arrhy	thmi	રે				hours
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	ا جام ا جام	Dicare	P		Harrier
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):	ir ter y	Diseas			at at 2
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
Ó,	e exectan an an urial-tr	Еха	resulting in death) Last	Due to (or as a	consequence of):					
68760,	ficate be executed g physician and is the burial-transit	edicai		l						
	T 00 m		IF FEMALE:	3c. If yes, outcome of	creanancy				22d Date of de	diana.
Вох	The law requires that the death certif the has been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at ti	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	′		23d. Date of de Month	Day Year
Ö.	t the c by the	hysi	9 Unknown	9□ Unknown						
s, P	res tha signed be del		Part II. Other significant conditions con	-			,			o the cause of death?
ord	w requir been si should	ted	Renal failur	1 (1	1	ion, Br		1 ☐ Yes	2 <b>2 N</b> o 3 □ P	robably 4 Unknown
Vital Record	e law has b	Completed by	Cancer, Dia		heart	failure	<del>-)</del>	24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
aiF			hyponatremie	a, Keftu	X	-		1 Yes 2	No 1 □ Ye	s 2 No
Z.	Physicien: this certificant	o Be	25. Was case referred to medical examiner?	lospital:	t 2 ER/Outpa	0th	AF	th (Check only one		- of 6.1
of	g Physer this eral d	n: To	27. Manner of Death	28a. Date of Injury	28b. Tim	e of 28c. Injur	-	28d. Describe hov	ce 6 Other (Sperinjury occurred	эспу)
ion	Attending F death. ctor: After y the funer	atio	1 ■ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day	Ye <i>ar)</i> Inju		Yes 2 □No			
Division	Hospitel or Attending 44 hours after death. Funerel Director: Atter tely filled in by the funer	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm (Specify)	, street, factory, office		28f. Location (Stre City or Town,	et and Number or F State)	lural Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	edical C	29a. Certifier 1 ☐ Certifying Phy: (Check only one)	sician: To the best of ner: On the basis of a and manner state	examination and/o	eath occurred at the ti or investigation, in my o	me, date and place, prinion, death occur	, and due to the cau rred at the time, dat	use(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the within 2. To the Complet	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Mon	th, Day, Year)
	. >1-0		· m			D	62180		May 29	3,2005
			30. Name and address of pora in who co	ompleted cause of dea	ath (Item 23a) (Ty	pe, Print)	1 January	Enodos	in	3, 2005
			Fauzi Kizvi,	32. Registrar	West	7th ST	rect 1	remer	100	
	Sta Regist		31. Date filed (Month, Day, Year)	16 Augustran	J. Ignatu					
	3.00		IIIN V 3	1						

		State of Maryland  1 - State Registrer	•	riment of H Fificate of L		tai mygien Reg. N	71115	18592
		Decedent's Name (First, Middle, Last)				ate of Death	ay Year	3. Time of Death
Physici: /Medic		Stella Mae Alder			Ma	0.0		8:55 A
Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	4	c. County of Death	
		Carroll Hosptial Center		Westmins			Carroll	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I		If Under 1 Year Months Days		ate of Birth Month, Day, Yea	9. Birth	place (State or Fore ntry)
Director		214-32-4219 92 Usual Residence of Decedent	Yrs.		Ja	n 18, 19		
how I			y, Town or Loca	ation				10d. Inside City Lim
e de	Director	MD Carroll Moun	nt Airy					1 ☐ Yes 2X
or 28	Oire	10e. Street and Number		10f. Zip Code		10g. (	Citizen of What Cou	ntry?
23a		5690 Ridge Rd.		21771			ted State	
is faind. Siturul on their within 72 feets and location in the many and if Health and Mental Hygiene. Here 27 is marked other than "natural", or flems 23a or 28a-f show other traumatic event, the Mcdical Exentral must be recilified at	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Yes, Give		as Decedent of Hi Yes, specify Cuba ☐ Yes 2█ No	spanic Origin? (Specify n, Mexican, Puerto Rica Specify:	Yes or No- n, etc.)	14. Race - Ameri Black, White Specify: White	etc.
'natural'	ted b	3 ☑ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)		ent's Usual Occupa	ation during most of working	16b.	Kind of Business/Ir	ndustry
within year than "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Seamtre	O NOT use retired	)	Sev	ving Facto	ory
Hygin other ent, t	ပိ	17. Father's Name (First, Middle, Last)	! —		18. Mother's Name (Fin			
Mental arked c	To Be	Ira Parks			Lavada La	ne		
Ith and Men 27 is marke r traumatic		19a. Informant's Name/Relationship ( <i>Type, Print</i> ) Mitzie Alder (Daughter-inlaw)			and Number or Rural Ro • Mt. Airy,			o Code)
permit. Pages I and a Department of Health a Important: If Item 27 is any injury or other tra				ition (Name of atory or other plac			Location - City or T	
ant:		'4 □ Donation 5 □ Other (Specify) Pine	e Grove		6/1/200	5 Mt.	Airy, MD	
Department of the control of the con	_	23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.		Name and Address		Home ar	nd Cremate	ory, P.A
hysician /Medical Examiner		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	were of):	ni w	diser	rded,	mforden	Interval Between Onset and Death
Examiner	er	Sequentially list conditions, if any, leading to immediate		aren	diser	パ		years
be executed ician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the consequence	mance of):					
cate be ex physician the burial	icai	d						
certifica Iding phi Ise as th	Me.	IF FEMALE: 23c. If yes, outcome of pregna	anov.				00d Date of dalls	
death e atter	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	ıl death 3 ☐E	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
w requires that the s been signed by th should be detache	by Ph	Part II. Other significant conditions contributing to death but not rest	ulting in the und	derlying cause giv	en in Part I.		o use contribute to	
en si	ed	acyfermers				1 🗌 Yes	2 Pro 3 □ Pro	bably 4 □Unkno
aw Is b	Completed by	hypotension				24a. Was an autopsy	prior to co	opsy findings availa
9 5 9	mo.					performed 1 Yes 2 21		2 No
ysician: In is certificate director, pag	Bec	25. Was case referred to medical examiner?	72		26. Place of Death (Ci			
S S	To	1 ☐ Yes 2 ☐ Mo Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 □ DOA Oth	er: 4 Nursing Home	5 🗌 Residence	6 ☐Other (Special	fy)
E = E		27. Manner of Death  1	28b. Time of Injury	28c. Injur Wor	v at 28d.	Describe how in		
ling After fune	=	Z [] /tooldon	omo form stro	at factors office	28f.	Location (Street City or Town, St	and Number or Rui	m I Classica Alemana e
After	ertificati	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At h building, etc. (Specify	fy)	et, ractory, office		.,	ate)	ai rioule ivumber,
After After Tune	edical Certification:	determined 288, Place of Injury - At It	fy) owledge, death	occurred at the tin		due to the cause	(s) and manner as	stated.
ling After fune	Medical Certificati	4 Homicide  determined  258. Place of Injuly Active building, etc. (Specifi  29a. Certifier (Check only 2 Medical Examiner: On the basis of examina	fy) owledge, death	occurred at the tir estigation, in my o	pinion, death occurred a e number	due to the cause t the time, date a	(s) and manner as	stated. to the cause(s)
ling After fune	Medical	4 Homicide  determined  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my known and manner stated.	owledge, death ation and/or inve	occurred at the tire estigation, in my o	pinion, death occurred a e number 26499	due to the cause t the time, date a	o(s) and manner as and place, and due of the signed (Month)	stated. to the cause(s)  Day, Year)
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.	Medical	4 Homicide  determined  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my known one)  1 Medical Examiner: On the basis of examinal and manner stated.	by b	occurred at the tire estigation, in my o	pinion, death occurred a e number	due to the cause t the time, date a	o(s) and manner as and place, and due of the signed (Month)	stated. to the cause(s)  Day, Year)

ORIGINAL

	•	For State Registrar	State of Maryland / [	Depar		ealth and N	Mental Hy	_	5   8594
Physicia /Medica Examine	al	Decedent's Name (First, Middle, La      Jean Harlow     4a. Facility Name (If not institution, giv	Eckert Avery		4b. City, Town, or	Location of Death	2. Date of Dea Month May		
Funeral Director		616 Nautilus Ave 5. Social Security Number 216-28-9442	ex 7. Age (In yrs. last bir		Balti If Under 1 Year Months Days	MOre If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Feb. 26	h y, Year)	Arunde1  Birthplace (State or Foreign Country)  MD
Be-f show	ctor	Usual Residence of Decedent  10a. State  Maryland  Anne A	rundel 10c. City, Tow	n or Loca	Balt	imore			10d. Inside City Limits 1 ☐ Yes 2√ No
uh with th 23e or 2 1st be na	Funeral Director	10e. Street and Number 616 Nautilus Ave	nue		10f. Zip Code	21225		10g. Citizen of Wh	at Country? SA
5-0036 72 hours after death with the Maryland neturel', or Items 23e or 28e-f show disal Ever ill art most be motified at	by Fune	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ※ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		as Decedent of H 'es, specify Cuba ☐ Yes 2 ☑ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White
Iltimore, Maryland 21215-0036  nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar ariment of Health and Mental Hygiene.  ortent: If tiem 27 is marked other than "neturel", or items 23e or 28e-f show injury or other treumatic event, the Medical Ever it ariman be indiffied at 8.	Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Give kii life. DC	nt's Usual Occupi nd of work done of NOT use retired Honse Tr	during most of worl l)	king	16b. Kind of Busin	ing
Maryland 2 d 2 should be filed th and Mental Hyg Z7 Is marked other treumatic event,	To Be C	17. Father's Name (First, Middle, Last, George Allen  19a. Informant's Name/Relationship (	Eckert	Mailing	Addraga (Street	Viola _	Elizabe	Maiden Surname)  eth BOW  or, City or Town, St	ling
ore, Mar. ss 1 and 2 sho of Health and item 27 Is m.		Vernon Morris  20a. Method of Disposition	(SOn) 3	301 (		e Road, F	asadena Date	, MD 2112 20c. Location - Ci	22
Baltimore, permit. Pages 1 at Department of Hee Importent: If item any injury or othe		1 Burial 2 Coremation 3 C 4 Donation 5 Other (Special Signature of Funeral Service License)	W) Metro	Crem	natory II	nc. 2000	Stalling		e, Maryland 1 Home, P.A. D 21122
Physician /Medical Examiner		23a. Paff 1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the seth. Do one cause on each line.  a. Due to (or as a consequence	an		g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Final Indianting Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence  C.  Due to (or as a consequence)						
176 Ite be Iysicie	cai	IF FEMALE:	_ d						
P.O. BOX nat the death cert do by the attendin etached for use	Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		ctopic pregnancy Other (specify)			23d. Date of Month	,
Records, P.O. Be The law requires that the death the has been signed by the atte age 2 should be detached for	ted by P	Part II. Other significant conditions of	contributing to death but not resulting in	n the und	erlying cause give	en in Part I.	23e. Did to		ute to the cause of death?  Probably 4 Unknown
of Vital Records, Physicien: The law requires tribis certificate has been signeral director, page 2 should be e		25. Was case referred to medical	Hebri 4	-au	ane_	26. Place of Dea	1 Tes	priormed? dea 2) No 1 [	re autopsy findings available or to completion of cause of the cause o
☐ g egg	cation: To Be	examiner?  1 Yes 2 X No  27. Manner of D th  1 X Natural 5 Pending 2 Accident investigation	(Month, Day Year) I	utpatient Time of Injury	28c. Injun Worl	er. 4 🗀 Nursing H	ome 5 X Resid	dence 6 Other	
Divisio To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	al Certification:	3 Suicide 6 Could not be determined	building, etc. (Specify)	e, death c	occurred at the tim	ne, date and place.	City or Tow	m, State)  cause(s) and mann	or Rural Route Number, er as stated.
To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Example (Check one)	niner: On the basis of examination an and manner stated.	nd/or inve	stigation, in my o	pinion, death occur e number	red at the time, o	date and place, and	d due to the cause(s)
X		30. Name and address of person who SALVACON D. R	2. Kawule n completed cause of death (Item 23a) Camine Z. M.D.	(Type, Pr		138912 Oakw Brun	on 1	vad f	Le 30%
Stat Registra		31. Date filed (Month, Day, Year)	82. Registrar's Signature	head	67/In	Brum	è Mo	21061	,

		1 - For State Registrar	State of M	aryland / Depa <i>Cel</i>	artmen <i>rtificate</i>			and M		ene	05	8595
0_		1. Decedent's Name (First, Middle, Las	t)				-		2. Date of Death Month	Day	Year	3. Time of Death
Physic		Sallie Bagley							May 25,		Teal	7:53 AM M
/Medi Examir		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of	of Death		4c. County	of Death	
LAGIIII		Shady Grove Ho	spital		Roo	ckvi	1.1.e			Montg	omer	V
Funeral		5. Social Security Number 6. S	9x 7. Ag	ge (In yrs. last birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birth			place (State or Foreign intry)
Director		234-88-7746	□ M 2∏ F	55 Yrs.	Wioritis	Days	Tiours	IVIII I.	8. Date of Birth (Month, Day, Apr 4,	1950	Vir	gínia
P .		Usual Residence of Decedent		10- 0: 7								40d Inside City Limite
rylar	_	10a. State 10b. County		10c. City, Town or Lo								10d. Inside City Limits
within 72 hours after death with the Maryland with in?2 hours after death with the Maryland nee. then "neturel", or Items 23e or 28e-1 show he Medical Examinar must be multiled at	Completed by Funeral Director	MD Montgom	ery	Rockvil								1 ☐ Yes 2√2 No
ifn th	Sire	10e. Street and Number			10f. Zip				10	og. Citizen of	What Cou	untry?
23e	le l	725 Monroe Stree				2085				USA		
ems	ine	11. Marital Status unk	<ol> <li>Was Decedent Armed Forces?</li> </ol>	Ever in U.S. 13.	Was Deced If Yes, spec	dent of Hi cify Cuba	ispanic Ori n, Mexicar	gin? (Sp 1, Puerto	ecify Yes or No- Rican, etc.)		ce - Amer ck, White	ican Indian, , etc.
or it	F.	1 Never Married 2 Married	1 ∐ Yes 2 XX If Yes, Give	No	1 ☐ Yes	2 <b>X</b> No	Specify:			Specif	y: b1	ack
ureli',	d b	3 Widowed 4 Divorced	Year or Dates:	52					12			
d within 72 hours aff giene. er then "neturel", or	ete	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece (Give	dent's Usua kind of woi DO NOT us	nk done o	ation during mos	t of work	ing	16b. Kind of B	usiness/i	ndustry
Men ellip	d E	Elementary/Secondary (0-12)	College (1-4or	5+) "//6.		30 1011100	,			foo	t foo	o d
filed v Hygie other t		11 17. Father's Name (First, Middle, Last)		200	)K	unle	18 Moths	ar's Nam	e (First, Middle, N			unl
be fi	Be	17. Falliel S Name (First, Middle, Last)				ulik	ro. moure	31 3 144.11	o (i noi, imaalo, ii			ann
is 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23e or 28a-1 show other treumetic event, the Medical Examinational Deutstillied at	ို		5 0	105 14-17		(C++++		0	-1 O-14- Nomber	City as Taylor	Ctata 7	in Codel
2 shot and is my		19a. Informant's Name/Relationship (			•				a <i>l Route Number,</i> 1 Rockvi	-		0850
and lealth m 27		Ermin H. Jakeson	Jr/friend	20b. Place of Dispo			Lieer			20c. Location		
int of H		20a. Method of Disposition  1   Burial 2   Cremation 3	Removal from State	cemetery cre-	matory or o	ther plac	e)		Date	EUC. EUCAHOIT	· City UI I	TOWIT, State
nit. Pag partment ortent: injury c	1	`4 □Donation 5 🔯 Other (Specif		<u> </u>								
permit. Pages 1 and Department of Health Importent: If item 27 eny injury or other trong.		21. Signature of Funeral Service Licer Ronald S	Wade Dix	estor Si	2.Namean tate <i>l</i> altimo	d Addres	ss of Facili omy B MD	oard 2120	655 W.	Baltim	ore	Street
Physician /Medical Examiner	Examiner	Part 1. Inter the disease, or com shock, I heart failure. List only Immediate Cal se (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate for the conditions of the condition	a Due to (or as	ine.  2 10 CA CC s a consequence of):				~				Approximate Interval Between Onset and Death
ite be executed sysician and ne burial-transit		that initiated events resulting in death) Last	Due to (or as	s a consequence of):						ø		
g pt as t	Aedical	IF FEMALE:	d									
. 0 0 0	Completed by Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	⊒Ectopic pi ⊒ Other (sp						ite of deli-	very Day Year
w requires that the been signed by the should be detached	d by Pt	Part II. Other significant conditions of	ontributing to death	but not resulting in the t	nderlying o	ause giv	en in Part I	l. 				the cause of death?
ne law has b ge 2 sl	Sompleto								24a. Was ar autops perform 1 \sum Yes 2	y ned?	Were aut prior to c death? 1  Yes	topsy findings available ompletion of cause of
ysicien: Thysicien: The is certificate director, pag	Be (	25. Was case referred to medical examiner?					26. Place	e of Dea	th (Check only one	θ)		
07	To 1	1 ☐ Yes 2 ☐ HO	Hospital: 1 Lapat	ient 2 ☐ ER/Outpatie	nt 3 DC	Oth Oth	er: 4 🗆 Nu	ursing He	ome 5 Reside	nce 6 Ott	ner (Spec	eify)
ding Ph h. After th funeral		27. Manner of Death 1 ☐Hatural 5 ☐ Pending	28a. Date of Inj (Month, Date	ury 28b. Time o	of 2	28c. injur Wor	y at k?		28d. Describe ho	w injury occur	rred	
Attending r death. ector: After by the fune	atlo	2 Accident investigatio			М	1 🗆	Yes 2 🗆	No				
IN SIGN OF Attending Phy after death.  Director: After this din by the funeral d	Certification:	3 Suicide 6 Could not be determined	200. Flace UI II	njury - At home, farm, st etc. <i>(Specify)</i>	reet, factor	y, office			28f. Location (Str City or Town		ber or Ru	ral Route Number,
To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the I	dical C			t of my knowledge, deal of examination and/or in stated.								
To the within 2 To the Comple	Med	29b. Signature and title of certifier			29	c. Licens	e number		29	9d. Date signe	ed (Month	n, Day, Year)
F 3 F ŏ		1 211-				7	1171	$\overline{}$				90 S
		30. Name and address of person who	completed cause of	death (Item 23a) (Type	Print)	DE	181			may 2	> , 20	
		30. Name and advises of person who	Micha	ol Coh	AKA	cr	1010	v,	Shac	ty G	rov	re Hospin
St Regis	ate trar	JUN 0 3 200	5 Herre	trar's Signature						J		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 2:15 Physician Ам Carole Ann Bauer 2, 2005 June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Genesis Elder Care Perring Parkway Parkville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 13, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 □ M 212 F 60 1944 Maryland 216 42 5378 Director Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits 10a. State 10b. County r than "naturel", or items 23e or 28e-f ehow the Medical Examinari, ust be notified at 1 ☐ Yes 2X No Carney Maryland Baltimore Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21234 2412 Cider Mill Rd. death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes < Z No
If Yes, Give
Year or Dates: 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker other 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Item 27 is marked oth any injury or other treumatic event 9DR8: Hazel Straight Charles Roland Bishoff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2412 Cider Mill Rd. Baltimore, Md. 21234 William Bauer (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 6/3/2005 Baltimore, Maryland Bayview Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 21. Signature/df Funeral Service License 1407 Old Fastern Avenue Essex, Md. 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus 100 each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician ardras disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) be detached Ö the 9 Unknown 9 Unknown Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ №6 Division of Vital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Mursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ № 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after acc.
To the Funerel Director: A death. investigation 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certified tale mis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reven Blvd, Baltimore, MD21239. 5601 Loch State 2005 Registrar

05-3696 B.K.S UNK. DARRELL BA

REL	L BANKS	,	For State Registrar	State of Maryland /	Department of He  Certificate of December 1985			20115	18597
			Decedent's Name (First, Middle, Last)		a continuate of D	Julia	2. Date of Death	J. No.	3. Time of Death
П	Physicia		DARREI	/	BANKS		MAY 29	Day Year 2005	0951 A <sup>M</sup>
	/Medic Examin		4a. Facility Name (I not institution give si 3200 BLOCK BELMON	reet and number) VI AVENUE	4b CALTIMOR	ocation of Death LE CITY		4c. County of Death	/A
	Funeral Director		212-12-2412	M 2□F		Hours Min.	8. Date of Birth (Month, Day, )	ear) Cour	place (State or Foreign ntry) -RYLAND
	and		Usual Residence of Decedent  10a, State 10b, County	10c. City. Toy	vn or Location			1	10d. Inside City Limits
	e Maryli Se-f sho lifted a	ctor	MARYLAND N	/A	12 -	MORE	CITY	/	1 Yes 2 No
	3a or 21	i Director	10e. Street and Number 4734 VANC	COUVER	10f. Zip Code	122	9 100	g. Citizen of What Cour	ntry?
920	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. It health and Mental Hygiene. Item 27 le marked other then "natural", or Items 23a or 28e-f show other traumatic event, the Medical Exam are must be collined at	by Funerai		2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hisp If Yes, specify Cuban, 1 Yes 2 No	panic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
215-0036	n 72 ho "natur edical i	eted	15. Decedent's Educ (Specify only highest grade	ation 16a	Decedent's Usual Occupation     (Give kind of work done during life. DO NOT use retired)	on ring most of worki	ng 16	6b. Kind of Business/In	dustry
21	filed within Hygiene. Sther then "sther then "south then "south then "south then "south the Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	ROOFE			ROOFING	ComPANY
Maryland	ould be fill Mental Harked oth arked oth	To Be	17. Father's Name (First, Middle, Last)  CLARENCE	BA	WKS 1	8. Mother's Name	(First, Middle, Ma	aiden Sumame)	T4
ary	2 should and Men le marke	<b> </b>	19a. Informant's Name/Relationship (Typ		b. Mailing Address (Street and	d Number or Rura	I Route Number, (	City or Town, State, Zip	Code)
	1 and 2 Health a em 27 le		SHEILA NASH  20a. Method of Disposition	(SISTER)	29 SUR LI	NGTON	T. EOG	ELECO, ML	21040
nor			1. Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)		ery, crematory or other place) UTUS CEMETE			oc. Location - City or To	
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service License	1. Williams	22. Name and Address	of Facility BR	OUDA JA	RIFUNERA BALTO, M	MARYLAND L HOME
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death. Do	not enter the mode of dying,				Approximate Interval Between
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	- Gunshot w	lounds (2)	to necle			Onset and Death
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	ed sit	Jiner	if any, leading to immediate	Due to (or as a consequence	of):				
ó	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):				
68760,	cate be physicial the bu	dicai	d.						
.O. Box 6	The law requires that the death certific ate has been signed by the attending p bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. If yes, outcome of pregnancy  1 Live birth 2 Fetal deat  4 Pregnant at time of death  9 Unknown	h 3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delive Month	ery Day Year
4	quires that en signed by	by	Part II. Other significant conditions conf	ributing to death but not resulting	in the underlying cause given	in Part I.		cco use contribute to the	ne cause of death?
Vital Records,		Completed					24a. Was an autopsy performe	prior to con death?	psy findings available mpletion of cause of
Vita	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:	Cthor		(Check only one)	77	
of	Phys arthis araldi	1: 70	1X Yes 2 No 27. Manner of Death	1 Inpatient 2 EH/O	Time of 28c Injury a	4   Nursing nor	ne 5 Residen	ce 6 Other (Specify injury occurred	y) AT SCENE
ion	ending Fath. or: After he funer	ation	1 Natural 5 Pending investigation	May 2 2005		s 2 XNo	Si	shipert was s	yLoT
Division	ol or Attend after death Director: ,	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, f building, etc. (Specify)			281. Location (Stre City or Town,	_ if Bellmon	J-
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Medical C	29a. Certifier 1 Cartifying Physic (Check only one)	ician: To the best of my knowledger: On the basis of examination a and manner stated.	e, death occurred at the time,	, date and place, a nion, death occurre	and due to the cau ed at the time, date	se(s) and manner as st	lated.  the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	10 0	29c. License r	number		Date signed (Month, AY 30, 200	
•	7		30. Name and address of person who cor	noleted cause of daysh (Item 23a)	OCM	<u>E</u>	23	- 55, 200	
_			Tasha Z Green	berg M.D.	111 Ponn	Street	Baltimo:	re, Marylar	nd 21201
	Sta Registr		JUN 0 3 200	3 Begistrar's Signature	Goods			, <del></del>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 12:01 AM /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL 8. Date of Birth Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 9 M 2 □ F 234-66-0907 VIRGINIA 0 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State other than "natural", or Items 23a or 28a-f show vent. the Medical Examinar must be notified at 1 ☐ Yes 2 HNo Director ANNE ARUNDE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1611 ARUNDI Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 14. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1□Yes 2□No If Yes, Give Year or Dates: UNK Specify: Baltimore, Maryland 21215-0036 JHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 7 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BOWEN E. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health a LOVE/NEPHEW IUN ARUNDLE RD EDGEWATER MD uepartment of Healt, important: if Item 27 any injury or other tr. 2000. 2103 THURMAN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ANATOMY GIFTS REG. 5/20/05 HANOVER, MD \* 4 Defonation 5 ☐ Other (Specify) 21. Signatu 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 264. Part 1. Enter the disease or complications the flassed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one sense of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DIR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1☐Yes 2☐No 3 ☐ Probably 4 ☐ Unknown Be Completed peen Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: Hospital: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Hatural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A 2 Accident in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of perspn who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) JUN 0

4000

egistrar's Signature

		· ·	State of Maryland				-	•	
<b>y</b>		1 - For State Registrar	otate of warytant	•	tificate of			g. No. 0 0 5	18599
		Decedent's Name (First, Middle, Last)					2. Date of Deat	1	3. Time of Death
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Examin		4a. Facility Name (If not institution, give s	reet and number)		4b. City, Town, o	r Location of Death		4c. County of Deat	th
	1	Northwest !	top; tel	nat birtholass)	If Under 1 Year	If Under 24 Hrs.	A Data of Birth	154/6	77
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Oct. 30,	Year) Co	hplace (State or Foreign buntry) CVland
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anylan show	-	10a. State 10b. County		, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
he Ma	ecto	MD Baltimor	e Ran	dallst	OWN 10f. Zip Code	-	14	Og. Citizen of What Co	
with t	- D	10e. Street and Number 10913 Steffeny Road			21133			Inited Stat	,
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or ite	Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		rYes, speciny Cuba I⊡ Yes 2 <mark>X</mark> INo	Specify:	Hican, etc.)	Black, Whit	e, etc.
ural'.	d by	3 X Widowed 4 □ Divorced	Year or Dates:					Wh	ite
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withi iene. r than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	House		•		Her Home	
e filed at Hyg other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, N		
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural; or thems 23e or 28e-f show aumatic event, the Medical Examinar must be revisibled at	To	John Earl Guetler				Marie Ve			
2 sho and is m		19a. Informant's Name/Relationship (Typ			,			City or Town, State, 2	
1 and Health em 27 ther t		Bruce Bowers  20a. Method of Disposition	Son 20b. PI		Shortlea sition (Name of natory or other plac			ourg, MD 21	
Pages nent of int: If it		1 🖫 Burial 2 □ Cremation 3 □ Re 14 □ Donation 5 □ Other (Specify)	miovai from State		natory or other plac Cemetery	June	6,		
- 5 # 5 E		21. Signature of Funeral Service Licence		22	Name and Addre	2005 ss of Facility	- tipe for	oodlawn, M	
Depare Impo		Xamu B Co	alle	Bu	irrier- u 12 W. Ol	een Funer d Liberty	al Home Road W	& Cremator	型,PiA:
		23a. Parl . Enter the disease, or complice shock, or heart failure. List only on	ations hat caused the death e caused on each line.	. Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
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/Medical Examiner		sulting in death)	Due to ( as a consequ	renc of):					
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be exec ician an burial-tr		resulting in death) Last	Due to (or as a consequ	ence of):					
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	lical	d							
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equire en sig							1 ☐ Ye	s 2月No 3∏Pr	obably 4 Unknown
law re as be	Completed						24a. Was ar	y prior to	utopsy findings available completion of cause of
ician: The lav certificate has rector, page 2:	Con				· · · · · · · · · · · · · · · · · · ·		perform 1 Yes 2		2 No
ysician: The lis certificate hadirector, page	Be	25. Was case referred to medical examiner?	ospital: Am.		t 3CLDOA Oth	oe.	h (Check only on		
Phys	. To	1 Yes 2 No	28a. Date of Injury	ER/Outpatien 28b. Time of	28c. Injur	y at	me 5 ☐ Heside 28d. Describe ho	nce 6 Other (Spe w injury occurred	city)
nding R tth. r: After e funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	M 1	rk? Yes 2 □ No			
Atternation of the part of the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Str City or Town	reet and Number or Ru , State)	ural Route Number,
ital or rail Distriction									
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To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	29	9d. Date signed (Mont	h, Day, Year)
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16		30. Name and address of person who co	mpleted cause of death (Item	23а) (Туре,	Print)	3/14	<del> </del>	-11061	0
		Alico Hsinh	WITH WA	pt /	Hopp:	tal R	sudali l	Xun,	boxy land
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ure	20	•		,	1
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		Decedent's Name (First, Middle, I	Last)						Date of Dea	th	V	3. Time of Death
Physici /Medi		Robert Carroll E	Baker					Jı	month ine 2,	2005	5 Year	3:00 A M
Examir		4a. Facility Name (If not institution, g	ive street and number)			4b. City, Tov	vn, or Locatio	n of Death		1 .	County of Dea	th
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Funeral Director		5. Social Security Number 6 215–16–1974	. Sex 7. Ag 1 🕅 M 2 🗆 F	je (In yrs. last 83	Yrs.		ays Hours	s Min.	Date of Birth (Month, Day) arch 1	, Year)	Co	thplace (State or Foreign puntry)  ryland
		Usual Residence of Decedent						r i	arch i	J, 1	724 1141	
arylar show	_	10a. State 10b. County		10c. City, T								10d. Inside City Limits 1 ☐ Yes 2 🕅 No
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with Sa or	2	3615 Stoneybrook	Road			2113				-	ed Stat	
death	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S.	13.			Origin? (Specifican, Puerto Ric			4. Race - Ame	arican Indian,
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yrand ould be file Mental Hy sarked oth	To.	Oscar Fuhrman Ba						a Lee (				
DESILITIOTE, INTERVIGITION ZIN 10000  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "neturel", or Items 23a or 28a-1 show any injury or other traumatic event, It a Medical Examination to the collised at 2006.		19a. Informant's Name/Relationship				ng Address (St L <b>1wood</b>		nber or Rural F	Route Number ysville			
Healt Healt tem 2	1 8	Diane Garro  20a. Method of Disposition	Daughter			sition (Name on matory or other		Dat			ation - City or	
Pages ent of nt: If If		1 M Burial 2 ☐ Cremation 3  1 4 ☐ Donation 5 ☐ Other (Spe	Removal from State			matory or other Mem. I		June 6 2005	,	Sukos	sville,	MD
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DO Jeath atter	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1⊡Live birth 4⊡Pregnant ai	2 Fetal de	ath 3[	Ectopic pregn Other (specif				-	Month	Day Year
by the tached	hysi	9 🗆 Unknown	9 Unknown						T			
The COLORS, P.O. Do	þ	Part II. Other significant conditions					e given in Pa	rt I.				the cause of death?
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he law requires to has been signed as been signed ge 2 should be on	Completed	Chronic Ly	mohocytic	Leop	cem	1			24a. Was a autops perfor	sy		utopsy findings available completion of cause of
ill in	e Co	25. Was case referred to medical					00.81		1 Yes	2.kk No		2 □ No
Or VITA Physician: rthis certific raf director,	O B	examiner?  1 \( \sum \text{Yes}  2 \sum \text{No} \)	Hospital: 1 ☐ Inpatie	ent 2∏ER	/Outpatier	nt 3□ DOA	Other	ace of Death (6 Nursing Home			₩Other (Soe	city) Hospice
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endin sath. or: Af	atic	1 Natural 5 Pending 2 Accident investigat	tion			М	1 Yes 2	□No				
INSION  or Attending after death. Director: Afte	Certification:	3 Suicide 6 Could not 4 Homicide determine	286. Place of in	iury - At home c. (Specify)	, farm, str	reet, factory, of	fice	28	f. Location (S City or Tow		Number or Ri	ural Route Number,
pital cours a cerel C		29a. Certifying	Physician: To the best	al my kaossie	due deal	n occument as to	na time, date	and place, and	i one to the c	auseis) a	ido madoar as	s sialeu
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edicai	(Check only 2 Medical Ex	aminer: On the basis of and manner st	f examination	and/or in	vestigation, in	my opinion, d	leath occurred	at the time, o	late and	place, and due	to the cause(s)
To th Within To th	Me	29b. Signature and title of certifier	150			1	cense numbe				signed (Mont	
1		1 M Auth	my Rily	· m	)	100	250	05		JU	re 2,0	2005
14		30. Name and address of person wh		death (Item 23	Ba) (Type,	Print)	5. (7	Bal	to. M	6	21201	ke
\ /	ate	31. Date filed (Month, Day, Year)					J ( )	,	-, -		/	
Regist		JUN 0 3	2005	rar's Signature	1	and I						

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amend item#10per, FH C844, 6/3/05 TT State of Maryland / Department of Health and Mental Hygiene 1 5 1 - For State Registrar Certificate of Death Reg. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 31, EZEZ5 **Physician** MAY 4:30A Timothy Ralph Bowen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Saint Joseph Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1EM 2□F Days Hours Min. Yrs. Director 0 09/26/1953 294-52-4670 OH Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo MD Lutherville Timonium Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Court items 23a 8-B Quiet Stream United States death Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 ö Specify: Specify: 3 NWidowed 4 □ Divorced White "natural". 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Retail College (1-4or 5+) othar than Elementary/Secondary (0-12) Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if itam 27 is marked oth any injury or other traumatic avant 2008. Be Max E. Bowen Ann L. Morgan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lisa Bowen / Sister 7-2D Warren Lodge Court Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jun 2 Beltsville, Maryland 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory Inc. 2005 21. Signature of Funeral Service-Licensee 22. Name and Address of Facility 22. Name and Address of Facility

Cremation and Funeral Alternat

8717 Green Pastures Drive Bal

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Approximate Interval Between Onset and Death Immediate Cause (Final Prosician IVER FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner LIVER CIRRHOSIS OF Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Physiclan/Medical Examiner Due to (or as a consequence of) or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760. attending physician as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, pe 3 ☐ Probably 4 Onknown 1 ☐ Yes 2 ☐ No SEPTICEMIA page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 🗌 Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1) Inpatient 2[ ate of Injury (Month, Day Year) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To tha Funaral I completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 02 D 37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON MARYLAND 21204 Registrar

State of Maryland / Department of Health and Mental Hygiene ( 18602 AMEND ITEM #19b PER FH C846 8 Jiffs Atts of Peath 2. Date of Death 3 Time of Death May 9, 2005 **Physician** John Bartee 7:00am<sup>™</sup> /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner PG 12010 Birchview Dr. Clinton tf Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) New York Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**火** M 2□ F 62 578-56-7470 Vre Director Usuat Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show s 23a or 28a-f ehov 1 Yes 2 No Director MD PGClinton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20735 12010 Birchview Drive U.S. Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

V☐ Yes 2☐No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status the Medical Examiner filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No **Black** ŏ Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) then Bus Driver Washington Times Pages 1 and 2 should be filed withment of Health and Mental Hygier trant: If item 27 is marked other thiury or other traumatic event, Illury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Lillie Mae James Bartee Jack ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12010 Birthview Drive, Clinton, MD 20735 19a. Informant's Name/Relationship (Type, Print) (wife) Sharon A. Bartee 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

X□ Burial 2 □ Cremation 3 □ Removal from State Date 20c. Location - City or Town, State Depertment of himportant: If its any injury or of once. 05-14-05 Mt. Olivet Cemetery Wash. DC 4 ☐ Donation 5 ☐ Other (Specify) Austin Royster Funeral Home permit. Depertn 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 3821 14th Street, NW, Wash DC20011 Approximate Interval Between Onset and Death 23a. Part I. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each thine. Immediate Cau e (Finat disease or condition **Physician** HYPERTENSION 10 years /Medical resulting in death) Due to (or as a consequence of) Examiner DIMBETES 4 cais Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed months ATRIAL FIBRILLATION physicien ans the burial-tr Due to (or as a consequence of): Box 68760, Physician/Medical DIVERTICULAR as attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funerel Diractor: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide To the Hospitel filled 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 060927 mi 5/16/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6104 old Branch Ave Temple Hills MUD Year whate Jeong Jem Wir 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 3 2005 Gosta Registrar

			1 - State Of State Of Registrer		artment of Health and M rtificate of Death		ene () () 5 g. No.	18603
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month May 18,	2005 Year	3. Time of Death 11:25 PMM
	/Medic Examin	al	Michael Branigan  4a. Fecility Name (If not institution, give street and nun  Joseph Richey Hospic		4b. City, Town, or Location of Death Baltimore	may 10,	4c. County of Deat	
	Funeral Director		5. Social Security Number  218-34-1230  Cusual Residence of Decedent	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month Day, ) June 16,	9. Birtl Co	nplace (State or Foreign untry) unk
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "naturel" or items 23e or 28a-1 show or other treumetic event, the Medical Examinar cust be notified at	by Funeral Director	10a. State 10b. County MD  10e. Street and Number 521 Allendale Street	10c. City, Town or Lo  Baltin  dent Ever in U.S. 13.			g. Citizen of What Co USA 14. Race - Ame	4
21215-0036	2 hours after of aturel', or Iter cal Examinar	ted by Fur	1 Never Married 2 Married 1 Yes, Giv Year or Da	2 No ulik ettes:	1 ☐ Yes 2 ☐ No Specify:	unk 16	Black, White Specify: 6b. Kind of Business/	white
nd 21215	permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items eny injury or other treumatic event, the Medical Examination once.	Be Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1 unk  17. Father's Name (First, Middle, Last)	life.	kind of work done during most of work DO NOT use retired)  unk 18. Mother's Name	e (First, Middle, Ma	aiden Sumame)	unk
Maryland	nd 2 should be lith and Menta 27 is marked r treumatic e	Tof	19a. Informant's Name/Relationship (Type, Print)  Joseph Richey Hospice		ng Address (Street and Number or Run N. Eutaw Street Ba		•	
Baltimore,	. Pages 1 ar Iment of Hea tent; If item jury or othe		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from 3  '4 □ Donation 5 ☑ Other (Specify) in Sta	ate	natory or other place)		0c. Location - City or	
Ball	permit Depart Impor eny in	n 4	21. Signature of Euneral Service Licensee Ronal d S Wade , Wade , 22. Part 1. Prier the disease, or complications that co	Ба	Name and Address of Facility Late Anatomy Board altimore, MD 2120	1		Street
8760,	death certificate be executed  P W W Se attending physician and correct to a set the buriat-transit	dical Examiner	shock, of heart failure. List only one cause on elimediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  C.	or as a consequence of):	er the mode of dying, such as cardiac of	or respiratory arres	n.	Approximate interval Between Onsel and Death
O. Box 6	the death certific / the attending pl ched for use as t	by Physician/Me	in the past 12 months?	ant at time of death 5	⊒Ectopic pregnancy ⊒ Other ( <i>specify</i> )		23d. Date of deli Month	very Day Year
Records, P.	The law requires that the de ate has been signed by the a bage 2 should be detached	Completed by Ph	Part II. Other significant conditions contributing to de	ath but not resulting in the u	nderlying cause given in Part I.		24b. Were au	./
Vital Re		Be Com	25. Was case referred to medical		26. Place of Deat	performe	death 1 ☐ yes	2 No
Division of Vi	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Certification; To B	27. Man er of Death  1 Natural 5 Pending investigation  2 Accident investigation  3 Suicide 6 Could rot be determined	h, <i>Day</i> Ye <i>ar)</i> Injury of Injury - At home, farm, str	ont 3 DOA Other: 4 Nursing Ho  f 28c. Injury at Work?  M 1 Yes 2 No	me 5 ☐ Residen 28d. Describe how	to 6 (7) other (Spector injury occurred the set and Number or Ru	my in
Ö	ospitel or hours atte unerel Dir		29a. Certifier 1 Certifying Physician: To the		h occurred at the time, date and place,	and due to the cau	use(s) and manner as	
	To the H within 24 To the Fa	Medical	29b. Signature and title of certifier	er stated.	vestigation, in my opinion, death occurr		/	n, Day, Year)
)			30. Name and address of person was commetted caus	e of death (Item 23a), (Type,	1/30/2 Print)	Billo	5/19/	NE 2121A
	Sta Regist		31. Date filed (Month, Day, Year)  JUN 0 3 2005	egistrar's Signature	GE GUI VII 11G	101111	/ //// ×	/2/0
	riegisti	-Cil	2014 0 0 5002					

			1 - For State Registrar	State of I	Marylar	nd / Depa	artment	of He	alth a		ental Hyg	giene ()	05	186	04	
	Physici /Medic		1. Decedent's Name (First, Middle, La	Bu	4						2. Date of Dea Month		2 eog	3. Time o	f Death	
	Examin												4c. County of Death  N/A  9 Birtholace (State or Foreign			
	Funeral Director			M 2□F	92	Yrs.	Months [	Days	Hours	Min.	MAR. 11,	9. Birthplace (State or Foreig Country) MASS.				
	the Maryla 28e-f sho	rector		IMORE			IMORE	Code				10g. Citizen	of What Coun	1 🗌 Yes	2 No	
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "neturel", or Items 23e or 28e-f show event, the Modical Examinar must be mailfied.	by Funeral Director	2320 FALLS GABL  11. Marital Status  1 Never Married 2 Married 3 © Widowed 4 Divorced	12. Was Decede Armed Force 1  Yes 2 If Yes, Give Year or Date	ont Ever in U es? X No	.S. 13. \	Was Deceder f Yes, specify		2120 panic Orig Mexican, Specify:		ecify Yes or No- Rican, etc.)		Race - America Black, White, e			
21215-0036	filed within 72 hour Hygiene. Ither then "neturel int, Ibe Mudical Ex	Completed b	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation		(Give	dent's Usual ( kind of work DO NOT use	done dui	ion ring most	of workii	ng	16b. Kind	of Business/Ind	lustry		
Maryland 2	should be filed and Mental Hyg s marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last, LOUIS  19a. Informant's Name/Relationship (			BURT			ROS	E	(First, Middle,	Maiden Sui	mame)	CUTTE	ER .	
Baltimore, Ma	t. Pages 1 and 2 rtment of Health a rtent: If Item 27 is rjury or other tre		ROBERT BURT / S  20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Special 2). Sign of Funeral Service	ON  Removal from Sta	ate (	2320 Place of Dispo cemetery, cren TIMORE	FALLS sition (Name natory or other	GAE of er place) W CE	BLE L	ANE 6/02	- UNIT	L BA	LTIMORE ion - City or To ISTERS	E, MD wn, State		
23a. Park. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one catise on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a insequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):									CILLE, N	Approxima Interval Be Onset and	te tween					
O. Box 68760,	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outco 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	n 2 ☐ Feta tat time of c	ancy	Ectopic preg	gnancy cify)				23d.	. Date of deliver Month	,	Year	
Records, P.	law requires tha as been signed I 2 should be det	Completed by P	A LANGE CONTINUE CONTINUENCE C										o 3 Proba	ably 4	Unknown	
Vital	sicien: The tav certificate has irector, page 2	25. Was case referred to medical examiner?									perfor					
Division of	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Certification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be determined	28b. Time of Injury	e of 28c. Injury at 28d. Describe how Work?  M 1 Yes 2 No						w injury occurred  eet and Number or Rural Route Number,					
	To the Hospitel or A within 24 hours after To the Funerel Directompletely filled in by	Medical Cert	29a. Certifier Certifying Pt	ysicien: To the be niner: On the basi and manner	s of examina	owledge, death	n occurred at vestigation, in	the time,	, date and nion, death	place, a	City or Town	ause(s) and	d manner as sta	ated. the cause(s	5)	
	To th within To th compl	Me	29b. Signature and the of certifier	5	M	2	De	DO6	number 24	04	- 1	29d. Date si	gned (Month, D	0ay, Year)	_	
	5		30. Name and address of person who	so La	istrar's Signa	erg N	Prince	exi	nd	de	_ (	<i>-</i>				
	Sta <del>R</del> egisti		31. Date filed (Month, Day, Year)  JUN 0 3	2005	Super Signa	D. A	mark!									

			1- For State of Maryland / I	-			ealth a Death	and M		giene	005	18605		
	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of Dea	2. Date of Death Month June 1, 2005 5:06F M				
	/Medic	al	Donald W. Coster, Sr.		41.00				Jui			5:06P M		
	Examin	er	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Cente					0W50		County of Death Baltimore				
	Funeral Director		5. Social Security Number 6. Sex 1 4 2 F 84 7. Age (In yrs. last bit 84	Yrs.	If Under Months	Days	If Under : Hours	Min.	8. Date of Birtl (Month, Day July 11	', Year)	9. Birth	place (State or Foreign ntry) ryland		
4,0			Usual Residence of Decedent						July II	., 17	ZO Ma	Tyrand		
	anylan show	_	10a. State 10b. County 10c. City, Tow	vn or Lo	cation						1	10d. Inside City Limits		
	he M. 28a-f	ecto	Md. Harford	]	Bel A							1 ☐ Yes 2 ☐ No X		
	with la or 3	Di	1307 Fordham Court		10f. Zip		014				n of What Cour	ntry?		
	death ms 23	era	11. Marital Status 12. Was Decedent Ever in U.S.	13. V	Vas Deced			jin? (Spe	ecify Yes or No- Rican, etc.)		Race - Americ	can Indian,		
ဖွ	or ite	by Funeral Director	1 Never Married 2 Married 1 3 Nover Married 2 No 11 Yes, Give	1			n, Mexican Specify:	, Puerto	Rican, etc.)		Black, White,			
003	ural',	d b	3 Wildowed 4 Divorced Year or Dates:								pecity: wh			
15-	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show fra Madeal Examilian mat be mulliad at	Completed	(Specify only highest grade completed)	(Give I	lent's Usua kind of wo DO NOT us	rk done d	luring most	of worki	ng	16b. Kind	of Business/In	dustry		
212	d with giene. r thar	ШО	Elementary/Secondary (0-12) College (1-4or 5+) 6 years bo		rmake		•			const	tructio	n		
pu	al Hyg	Bec	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name	(First, Middle,	Maiden Su	ımame)			
yla	2 should be filed w n and Mental Hygier is marked other th raumatic event, III.	ဥ	Newton Coster		_				e Wirth					
, Mar	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Noolical Examinating the indiffed at								Route Numbe	-		Code)		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra snce		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of cemete				1				tion - City or To			
	nit. Pa artmei ortant injury e.	ì	'4 □ Donation S □ Other (Specify) Bayvi  21. Signatur → Fundal Service Licenses				s of Facilit		4, 2005	Вал	ltimore	, Md.		
	Per Sun		Actif CIV	1	Schi	mune	k Fun	era1	Home o	f Bel	L Air,			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Anoxic Ence	Anoxic Encephalopathy								Onset and Death		
	/Medical Examiner		Due to (or as a consequence of):  Coronary Artery Bypass Graft Surge											
		ē												
1	cuted nd ransit	m   that initiated events												
8760,	cate be executed obysician and the burial-transit	EX	resulting in death) Last Due to (or as a consequence	of):										
687	ficate I physi s the b	edicai	d											
Вох	eath certific attending p	In/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	- 2	l <del>-</del> :					230	I. Date of delive	ery		
	e deat	by Physician/Me	in the past 12 months?  1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown		Ectopic pr Other (sp						Month	Day Year		
P.O.	that the de led by the a detached i	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting i	in the ur	nderlying c	alise dive	n in Part I		23a Did to	hacco use	contribute to th	ne cause of death?		
Records,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ed by	ACUTE RENAL FAILURE						1 □ Y	/		ably 4 Unknown		
ecc	has be	Completed							24a. Was a autops		24b. Were auto	psy findings available mpletion of cause of		
	: The								performula 1 Tes	ned? 2 No	death?	2) No		
Vital	siciar certif iractor	o Be	25. Was case referred to medical examiner?  1   Yes 2   No   Hospital: 1   Inpatient 2   FR/O			Othe	-		(Check only or					
of	Attending Physician: r death. ector: After this certific by the funeral director,	n: To	27. Manner of D ath 28a. Date of Injury 28b.	Time of		8c. Injury	at at	_	ne 5 🗌 Reside			y)		
ion	ttending death. ctor: Aft y the fun	atio	2 Accident investigation	Injury	М	Work	7 ′es 2 □ N	10						
Division of	i Sir de	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	am, stre	eet, factory	, office		2	8f. Location (Si City or Town		lumber or Rura	l Route Number,		
-	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by		29a. Certifier Certifying Physician: To the best of my knowledge	e, death	occurred	at the tim	e, date and	place, a	nd due to the c	ause(s) an	d manner as st	ated.		
	he Ho in 24 t he Fu pletely	Medical	(Check only one) 2 Medicel Examiner: On the basis of examination an and manner stated.	nd/or inv	estigation,	in my op	inion, deat	n occurre	d at the time, d	ate and pla	ace, and due to	the cause(s)		
	To the within 2 To the complet	Σ	29b. Signature and title of certifier		290	. License	number		2	,	igned (Month,	Day, Year)		
			· Joan o Ca			D 30	9263			6-	1-5			
1	5-11		30. Name and address of person who completed cause of death (Item 23a)				<u>.</u>		h.s "		to an amountable of			
	Sta	te	Francis Khoo M. D. 7601 Os.  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Ler	UT1	V 6	OWSO	) Ti y	Maryla	nd E	1204			
	Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	<b>254</b> 6										

			1- State of Maryland / Departm	nent of Health and M cate of Death		iene <sub>9g. No.</sub> 2005	18606			
	Physicia		1. Decedent's Name (First, Middle, Last) Brendan Gerard Crowley		2. Date of Deal	b Day 2005 Year	3. Time of Death			
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b.	City, Town, or Location of Death		4c. County of Death	L			
			Southern Maryland Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	Clinton Inder 1 Year   If Under 24 Hrs.	8. Date of Birth	Charles	lace (State or Foreign			
	Funeral Director		219-72-5512 1 G M 2 F 43 Yrs. Mor	nths Days Hours Min.	February	/°25,1962 °58	Ston, MA			
	pu .		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			11	0d. Inside City Limits			
	Maryla f sho	ō	MD Charles Waldorf	,			1惯Yes 2□No			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23a or 28a-f show eny injury or other treumetic event, the Medical Examinating the notified of once.	Funeral Director		f. Zip Code 20601		Og. Citizen of What Coun	•			
	death	nera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was I Armed Forces? 13. Was I If Yes,	Decedent of Hispanic Origin? (Spe specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ Black, White,				
920	urs after ei', or ite Exemina	by	1 Never Married 2 Married 1 Yes 247 No	es 2 <sup>th</sup> No <i>Specify</i> :		Specify: White				
5	72 ho	eted	(Specify only highest grade completed) (Give kind of	Usual Occupation of work done during most of worki	ng	16b. Kind of Business/Inc	dustry			
21215-0036	within iene. than the Me	Completed	Elementary/Secondary (0-12)  12th  College (1-4or 5+)  Disable	OT use retired)		Disabled				
Maryland 2	d be filed intal Hygis ed other	Be	17. Father's Name (First, Middle, Last) John Joseph Crowley	18. Mother's Name Jean Robe		Maiden Sumame) Sey				
aryl	2 should be and Mental Is marked c	P	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Add	dress (Street and Number or Rura	I Route Number	. City or Town, State, Zip	Code)			
	and 2 saith a n 27 ls			ake Drive #238 V						
Baltimore,	Pages 1 nent of He int: If iter		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition cemetery, crematory	(Name of r or other place)	)ate	20c. Location - City or To	wn, State			
	nit. Pag artment ortent: b injury o		' 4 Donation 5 Other (Specify) Howard Medic  21. Signature of Funeral Service Licensee 22. Nam  22. Nam	cal School May 1 ne and Address of Facility Aust	18,2005	Washington,	DC			
æ	permit. I Departm Importer eny injui		22 00	3821 14	in Roys Ith St.	NW Washingto	nome on. DC 2001			
	death certificate be executed  Wedical  Examiner  of for use as the burial-transit	cal Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heartfailure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	len Acci			Interval Between Onset and Death			
O. Box 6	the death certifi y the attending I ched for use as	Physiclan/Medical	nysiclan/Medi	nysiclan/Medi	nysiclan/Medi		pic pregnancy er (specify)		23d. Date of delive Month	ry Day Year
S, D	es that igned b be deta	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underly	ring cause given in Part I.	23e. Did tot	pacco use contribute to th	e cause of death?			
ord	law requires as been sign 2 should be				1 □ Ye	es 2 No 3 Prob	ably 4 □Unknown			
of Vital Records,	0 4 0	Completed			24a. Was a autops perform	y prior to con ned? death?	osy findings available npletion of cause of 2 No			
/ita	Physicien: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	26. Place of Death	(Check only on	θ)				
of	Phys rthis ral dii		1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ EP/Outpatient 3 ☐ 27. Manner of Death 28a. Date of Injury 28b. Time of			ence 6 Other (Specify ow injury occurred	")			
ion	Attending Phradensing Phradeath, ector: After the system of the funeral	ation	1 Matural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation M							
Division	i or Atten after deat Director:	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, stree	actory, office	28f. Location (St City or Town	reet and Number or Rura n, State)	Route Number,			
_	Hospite 4 hours Funerel ely filled	ledical Co	29a. Certifier (Check only one)  1 Certifying Physician: To the basis of examination and/or investig and manner stated.							
	To the twithin 2. To the complet	Me	29b. Signature and title of certifier	29c. License number  D S 2 2 8 9	2	9d. Date signed (Month, L	Day, Year)			
,			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							
			Nalin Mathur MD. 10 St. Patricks Drive	Suite 404 Wald	orf, MD	20603				
	Sta Registi		JUN 0 3 2005	<b>U</b>						

			i lease	, .	f Maryland								-		
		•	1 - For State Registrar	Olaic o	i waiyian		rtificate			ATTO THE	_	Reg. No	4005	1860	
			Decedent's Name (First, Middle, L.)	ast)							2. Date of De	ath		3. Time of Death	
	Physicia		Leon A. Cu:	rtis							April	6	2005	8:00 a M	
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and nui	mber)		4b. City,	Town, or	Location o	of Death		40	c. County of Death		
			7829 Overhill	Road					urni			An	ne Arur		
	Funeral		Social Security Number     6.	Sex 1⊠M 2□F	7. Age (In yrs. Id	ast birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Bird (Month, Da	y, Year	9. Birth	place (State or Foreign intry)	
	Director		213-86-9461 Usual Residence of Decedent		33	113.				4	June 2	4 L	971 Mar	yland	
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits	
:	Mary	tor	Maryland Anne	Arunde1	Gle	n Bur	nie							1⊠Yes 2 No	
:	2 28 E	Director	10e. Street and Number				10f. Zip	Code				10g. C	itizen of What Cou	intry?	
,	23a (	rai	7829 Overhill	Road				210						JSA	
	tems	Funerai	11. Marital Status	Armed Fo		S. 13.	Was Deced If Yes, spec	lent of Hi rify Cuba	ispanic Orig n, Mexican	gin? (Spe 1, Puerto l	cify Yes or No Rican, etc.)	-	14. Race - Amer Black, White		
0	rs aff	by F	1  Never Married 2  Married  Uidowed 4  Divorced	1 □Yes If Yes, Gir Year or D	/e		1 ☐ Yes	2 <b>∑</b> No	Specify:				Specify: B1	ack	
20	be lied within 72 hours after death with the Maryland Hygiene. d other than "neturel", or Items 23s or 28e-1 show event, the Modical Exerciner must be relified at		15. Decedent's I	Education	1	16a. Dece	dent's Usua	I Occupa	ation			16b. I	Kind of Business/li	ndustry	
י מ ע	nin 7.	plet	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (	1-4or 5+)	(Give life.	kind of wor DO NOT us	rk done d se retired	during most  )	t of workii	ng				
7	be filed with tal Hygiene d other tha event, II.e. I	Completed	11th	0	,		Mech	ani					tomotiv	re	
2	tal Hy d oth	Be (	17. Father's Name (First, Middle, Las								(First, Middle,				
	should be filed within nd Mental Hygiene. I marked other than umetic event, ILE M.	은	Nathanie		.S	401 14 33		(0)			ntine				
=	12 sho h and 7 ls mu treum		19a. Informant's Name/Relationship Nicole Hillar		er)		-					-	or Town, State, Zince, $\mathbf{ie}$ , $\mathbf{Md}$ .		
ע	of Health item 27 other tr		20a. Method of Disposition	y (SISC	20b. Pl	ace of Disno	sition (Nan	ne of			ate		ocation - City or T		
	Pages nent of int: If it iry or o		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		State Hop	e St.	Mar	k U	. M .	1/10	/05	TO 40 40		Ma	
	- E E E		21. Signature of Funeral Service Lic		CHu		2. Na <i>m</i> e an	d Addres	s of Facilit	ty			ewater,	MG.	
ŏ	Departiment on the conce		Lavy 1 Re	ese NOL	483		Wm .	Ree	se &	Sor	ns Mor	tua	ry, P.A	401	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that of	caused the death	. Do not en	ter the mod	e of dyin	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between	
F	Physician		Immediate Cause (Final disease or condition	. C	bstru	tive	5/	000	ton	1001				Onset and Death	
	/Medical Examiner		resulting in death)	Due to	(or as a consequ	ience of):		1	1					1./	
	xaminer		Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):												
	ted rsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.												
_	be executed ician and burial-transit	Exar	that initiated events resulting in death) Last	c	(or as a consequ	ience of):									
	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	cail		d											
0	fifficat ng phy as th	edi	IC CCIVAL C	3/							-				
XOO .	th cer tendir r use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown								23d. Date of delivery  Month Day Year				
	e dea the at ned fo	Physician/M											Marini Day		
7.	hat th ad by detacl		Part II. Other significant conditions	contributing to d	eath but not resu	ulting in the u	ınderivina c	ause give	en in Part I.		23e. Did t	obacco	use contribute to	the cause of death?	
GS,	The law requires that the death certifica tie has been signed by the attending ph bage 2 should be detached for use as th	d by	obesity	<b>3</b>		3	, , ,				1 🗆	Yes 2	2□No 3□Pro	bably 4 Unknown	
ecords	w requ	ompleted	die be to mellifie 24a. Was an							an	24b. Were autopsy findings available				
Ž.	he lav e has ige 2	ошо	ala te ros me	Hirus							auto <sub>l</sub>	psy rmed?	prior to o death?	ompletion of cause of	
	(0 1	O	25. Was case referred to medical	T					26. Place	1 Yes 2 No 1 Yes 2 No					
	Physicien: this certific al director,	To B	examiner? 1 □ Yes 2X No	Hospital: 1 🗆	Inpatient 2 🗆	ER/Outpatie	nt 3 DC	Oth	er: 4 🗆 Nu	rsing Ho	me 5 Resi	dence	6 □Other (Spec	ify)	
			27. Manner of Death  1 Natural 5 □ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time o	i 2	8c. Injun Work	y at k?	- 1	28d. Describe	how inj	ury occurred		
S	tendia eath. or: A the fu	cati	2 Accident investigat 3 Suicide 6 Could not	be			М		Yes 2 🗌 I	No	201				
DIVISION	or At after d Direct in by	Certification;	3 Suicide 4 Homicide  5 Homicide  4 Homicide  5 Homicide  4 Homicide  5 Homicide  4 Homicide  5 Homicide  5 Homicide  6 Homicide  7 Homicide  8 Homici									ai Houte Number,			
	spitel ours and nerel i	aj C	29a. Certifier (Certifying)	Physician: To the	e best of my know	wledge, deat	th occurred	at the tim	ne, date an	id place, a	and due to the	cause(	s) and manner as	stated.	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	ledicai	(Check only 2 Medical Ex	aminer: On the b	pasis of exa <i>m</i> inat oner stated.	tion and/or in	vestigation	, in my o	pinion, dea	th occurr	ed at the time,	date ar	nd place, and due	to the cause(s)	
	To the within To the Comp	M	29b. Signature and title of certifier	1/1-			290	. License	e number			29d. D	ate signed (Month	Day, Year)	
			Pel / 48	ly	NN	12		22	1480	34		5	- 31-20	05	
	3		30. Name and address of person wh	) /		10	Print)	,		1		/	1,00	14/1	
			31. Date filed (Month, Day, Year)	ereiso			1	TM		1	mapel	51	-31-20 Wel 2	1501	
:0	Sta Registr			005	Registrar's Signa	Sport	West .								

amend item/16b, per Find 100 Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** LEON CUSHING MAY 31,2005 3:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Saint Joseph Medical Center Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | APR. 25, I 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) Funeral Months 1 ☑ M 2 ☐ F 1917 RUSSIA Director 040-14-4636 88 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No MD TOWSON BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ā 509 E. JOPPA ROAD USA 21286 Funeral 12. Was Decedent Ever in U.S Armed Forces? WW I 1 M Yes 2 □ No If Yes, Give Year or Dates: A RM Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. WWII Pages 1 and 2 should be filed within 72 hours after on the filed within 72 hours after one of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: ARMY WHITE δ Specify: 3 X Widowed 4 ☐ Divorced "natural" Completed th and Mental Hygiene.
?? Ie marked other than "natur treumetic event, the Wedgall Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) **Goldseker** Elementary/Secondary (0-12) College (1-4or 5+) PROPERTY & BUILDING INSPECTOR GOLDSELGER REALTY CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ISRAEL CUSHING SARAH (UNKNOWN) P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 le any injury or other tree once. DEBORAH DOPKIN / ATTORNEY 409 WASHINGTON AVE. #1000 - TOWSON, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 06/06/2005 4 ☐ Donation 5 ☐ Other (Specify) MD VETERANS CEM. OWINGS MILLS, MD 2111 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1 Erfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate cause (Final disease of condition **Physician** PNEUMONIA resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Compieted by Physician/Medical use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No CONGESTIVE HEART FAILURE 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? URINARY TRACT INFECTION has autopsy certificate 1 Yes 1 Yes Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Hospital: 1 ☐ Yes 2 🗙 No Other: 1 Inpatient ۵ 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Da e of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural 2' Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death
| Director: / 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours at To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only o the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie LOU, M.A r 31 D 17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

DSLER DRIVE TOWSON, MARYLAND 21204

			1 - For State Registrer	State of Maryla		artment of Heartificate of De		, ,	ene	75 1000	prop
	Physici		1. Decedent's Name (First, Middle, Las Paul G. Dougla					2. Date of Death	_	'ear 25/ P M	ز.
	/Medic Examin		4a. Facility Name (If not institution, give 3403 Cedar Chu	street and number)		4b. City, Town, or Lo Darlingto		f	4c. County of Harfor		_
	Funeral Director		210-02-3133	9x 7. Age (In yr	rs. last birthday) Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan 26,	Year) 1942	9. Birthplace (State or Foreign Country) Canada	7
	Maryland I-f ahow fied st	tor	Usual Residence of Decedent  10a. State 10b. County  MD Harf		City, Town or Lo				Topic The	10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	th with the 23e or 28a at Le noti	Funeral Director	10e. Street and Number 3403 Cedar Churc			10f. Zip Code	1034	10	g. Citizen of Wh Can	at Country?	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23e or 28e-f ahow any injury or other treumetic evant, its Medical Evantment mutil to routile 1 at ADR. ADR. ADR.	by Funer	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	l:	Vas Decedent of Hispa f Yes, specify Cuban, N ☐ Yes 2√2 No S	anic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. white	
21215-0036	hin 72 hour e. en *natural Medical E.	Completed t	15. Decedent's Ed (Specify only highest grades)	ucation	(Give	lent's Usual Occupatio kind of work done duri DO NOT use retired)		ng 10	6b. Kind of Busin		
	be filed with	Be	9 17. Father's Name (First, Middle, Last)	0	g			(First, Middle, Ma		farm	
Maryland	d 2 should th and Men 7 is marks treumetic	P.	John Gordon Dou  19a. Informant's Name/Relationship (7  Heather Ducharme/	ype, Print)		g Address <i>(Street and</i> endin Pkwy	Number or Rura	l Route Number,	City or Town, Sta		
Baltimore,	Pages 1 an ent of Heal nt: If item 2 ry or othar		20a. Method of Disposition  1 Burial 2 Cremation 3 Characteristics  1 Donation 5 Cother (Specify	20b Removal from State	. Place of Dispos	•	-			ty or Town, State	
Balti	permit. Departm Importe any inju		21. S gnature of Funeral Service Licen	Wade, pivect		Baltimore,	MD 21:	201		nore Street	
	Pnysician /Medical		23a. Part1. Enter the disease, or compands, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the de one cause on such line.  a. Due to (or as a cons	clerat	er the mode of dying, s	N		7	Approximate Interval Between Onset and Death	
,8760,	ficate be executed with physician and sthe burial-transit	al Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b							
.O. Box 687	death certii e attending d for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	,	
Δ.	quires that n signed b uld be deta	by	Part II. Other significant conditions co	entributing to death but not r	esulting in the ur	derlying cause given in	n Part I.	23e. Did toba 1 ☐ Yes		ute to the cause of death?  Probably 4 Unknown	
il Records,	The law requires that the cate has been signed by the page 2 should be detache	Completed						24a. Was an autopsy performe	prio dea	re autopsy findings available of to completion of cause of th? Yes 2 No	
Division of Vital	Attanding Phyaician: Thir death. ector: After this certificate by the funeral director, pag	ertification: To Be	27. Manner of Death Natural 5 Pending investigation 3 Suicide 6 Could not be	286. Place of Injury - At	28b. Time of Injury	Other:  28c. Injury at Work?  M 1 Yes	4 ☐ Nursing Hor	28d. Describe how 28f. Location (Stre	et and Number	(Specify) or Rural Route Number,	
ă	To the Hospital or Attand within 24 hours after death To the Funaral Director: completely filled in by the	O	29a. Certifier 1 Certifying Ph	building, etc. (Spe	nowledge, death	occurred at the time,	date and place, a	City or Town, and due to the cau	se(s) and mann	er as stated.	9
)	To the Ho within 24 I To the Fu completely	Medical	29b. Signature and title of certifier	iner: On the basis of exami and manner stated.	nation and/or inv	29c. License nu				Month, Day, Year)	-
		19	30. Name and address of pe don 10 of BERMAN J. VI	completed cause of death (It	INE 1	OS HOLAG	VRA AVA	E BAN	TO Ma	21222	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	Apartic Parties						

			-	State of Maryland / De			-	_	•
			1 - State Registrar	•	Certificate of D			Reg. No. 2 A A	10010
			Decedent's Name (First, Middle, Last)	4			2. Date of Dea	uth	3. Time of Death
	hysici: /Medic		ADA GR	AV DANIE	ELS		Month	28 20	05 10:25 AM
	xamin		4a. Facility Name (If not institution, give st		4b. City, Town, or I	Location of Death		4c. County of De	
			LORIEN FRANK	FORD NURSING-HON	E SA	LTIMO	RE	1	1A
Fu	neral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthe	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	, YearL	Birthplace (State or Foreign Country)
Dir	ector		210-16-8077	M 201 72 Yr	s. Sayo		OCT. 1	1,1932 N	ORTH CAROLINA
pur	- C-25	}	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town o	or Location			,	10d. Inside City Limits
anyla	e po	5	Ala authin	16		TILLOD.	- 11	-11	1'EYes 2 No
the N	289-	ect	10e. Street and Number	IA	10f. Zip Code	11701	E C17	10g. Citizen of What	Country?
with	ms 23a of 28a-1 chow	Funeral Director	4334000	NHILL AVENU		2121	16	// <	* /)
leath	ns 23	era	11. Marital Status		13. Was Decedent of His If Yes, specify Cuban	panic Origin? (Si	pecify Yes or No-	14. Race - A	nerican Indian,
of the r	irier	표	1 ☐ Never Married 2 Married	1 □Yes 2 No			o Rican, etc.)	Black, W	hite, etc.
UU36 hours after death with the Maryland	Extroller	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No	Specify:		Specify:	LACK
5-0036 72 hours af	natur lical	Completed	15. Decedent's Educ (Specify only highest grade	ation 16a. D	ecedent's Usual Occupat	tion uring most of wor	kina	16b. Kind of Busine	ss/Industry
within 72 ene.	M.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	Give kind of work done duife. DO NOT use retired)	A	_	411 -	c //
N 5 5	t, the	S	10THGRADE	$\mathcal{N}_{\mathcal{L}}$	URSING				NG HOME
land Id be filk ental Hy	evant,	Be	17. Father's Name (First, Middle, Last)	Bon	11-11	18. Mother's Nan	ne (First, Middle,	Maiden Sumame)	- 1
7 7 7	narke	٦	KOWERT	DKAS	WELL	MAK	y /	ANDER.	
Mary d 2 shouth and N	raun		19a. Informant's Name/Relationship (Typ	1111	Mailing Address (Street a	- 1 at 1	ral Houte Numbe	r, City or Town, State	
_ == 0	othar t		20a. Method of Disposition	AUGHTER) 4	Disposition (Name of	ENHIL	Date	20c. Location · City	MD 21206
altimore, mit. Pages 1 al	= ŏ =		1 Ø8urial 2 ☐ Cremation 3 ☐ Re	moval from State cemetery,	crematory or other place				
ting the	ortant: injury e.		'4 □Donation 5 □ Other (Specify)		DRIDGE CE	ME 06 -	03-05	PIKESVIL	IE, MD.
<b>Ba</b> Dermi	mpo any ir		21. Signature of Funeral Service Licenses		22. Name and Address		n .		
			23a Part 1 Enter the disease or complic	ations that caused the death. Do no	Joseph H.	Prown V	or respiratory ar	100/11mone	MD 212/7 Approximate
	- 1		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final						Interval Between Onset and Death
	ician dical		disease or condition resulting in death)	METASTATION  Due to (or as a consequence of)		EATIC	C/17V	ICER	
	niner		F	Due to (or as a consequence of,					
L .		e	Sequentially list conditions, it any leading to immediate cause. Enter Underlying	Due to for as a consequence of	t				
cuted	ansit	Examiner	Cause (Disease or injury that initiated events						
<b>60,</b> be executed	nysician and he burial-transit		resulting in death) Last	Due to (or as a consequence of)	:				
3 7 6 U	he bu	Ical	d.						
Hecords, P.O. Box 68 The law requires that the death certifica	attending phy I for use as the	Physician/Med	IF FEMALE:						
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S the second of	the a	/sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)	<del></del>			,
r hat th	ed by the a detached t	Ph	Part II. Other significant conditions cont	ributing to death but not resulting in t	he underlying cause giver	n in Part I	23e. Did to	bacco use contribute	to the cause of death?
ires t	E &	1 by			, , , , , , , , , , , , , , , , , , ,		1 🗆 Y		Probably 4 □Unknown
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e law	has t	du					24a. Was autop	sy prior t	autopsy findings available o completion of cause of
	cate , pag								es 2 No
Vital	this certificate has l	Be	25. Was case referred a medical examiner?	espital:	Othor		th (Check only or		
<b>5</b> €	a the	٦.	1 Yes 2 No	28a. Date of Injury 28b. Tin	atient 3 DOA	4 Nursing H		ence 6 Other (S)	pecify)
ding .	fune	tlor	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Inju	ury Work'	? es 2 □ No		. ,	
DIVISION I or Attanding after death.	y the	flca	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm	n, street, factory, office		28f. Location (S	treet and Number or	Rural Route Number,
after after	d in b	Certification;	4 Homicide	building, etc. (Specify)			City or Tow	n, State)	
ospita hours	inera y fille	alc	29a. Certifier 1 Certifying Physi	cien: To the best of my knowledge,	death occurred at the time	e, date and place	, and due to the o	cause(s) and manner	as stated.
DIVISION Of VITA To the Hospital or Attending Physician: within 24 hours after death.	To the Funeral Diractor: After completely filled in by the funer.	Medical	(Check only 2 Medicel Examin	er: On the basis of examination and/ and manner stated.	or investigation, in my opi	inion, death occu	rred at the time, o	date and place, and d	ue to the cause(s)
To tha within 2	com	Σ	29b. Signature and title of certifier	6	29c. License	number		29d. Date signed (Mo	
			They Chile		D006	0 5 60		JUNE 2	2005
	7		30. Name and address of person who con			0.1			
			201-109 BACK	21VER NECK RI 32. Registrar & Signatur	S. 15ALT 11	nort	, mo		
F	Sta Registr		31. Date filed (Month, Day, Year) 5	DOCK POSTER POSTER					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Daniels Ma 31 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Maryland Medical Center NA University 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1**X**M 2□ F 214-84-4231 Director Yrs Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MARYLAND 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 5 238 MOR SA Pages 1 and 2 should be filed within 72 hours after death a nent of Health and Mental Hygiene. snt: If item 27 Is marked other than "natural", or Items 23. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) THGRADE 17. Father's Name (First, Middle, Last) dher's Name (First, Middle, Maiden Surname, Be AMES ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (MOTHER) N. GILMOR MAGDALENE 20a. Method of Disposition 20b. Place of Disposition (Name of Department of F Importent: If ite any injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State STAR (EME 06 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FUNERAL FULTON AVE. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) HIDS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enar U lootlying Cause (Disease or injury Examiner Due to (or as a consequence of) anding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? for Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. F 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should be Be Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Nuknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 XNo 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only one Dther: Certification: To 1 ☐ Yes 2 X No 1 Sinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

Universit

Registrar's Signature

of Maryland

22 S. Greene St. Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JUN 0 3 2005

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State RegistrAMEND ITEM #1&10e PER PHY & th Certificate of Death RegistrAMEND ITEM #1&10e PER PHY & the Dea Reg. No. 2. Date of Death 3. Time of Death MATRIEW A. De MARINO Year Month **Physician** 55 A. M 2005 /Medical 4b. City, Town, or Location of Death Name (If not institution, give street and number) 4a. Facility 4c. County of Death Examiner onte TIMORE 0 m 20 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 M 2□F W. Yrs. Director -10 Usual Residence of Deceder with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Nadical Examinar must be notified at 1 ☐ Yes 2 No Director MORE HLTIMOR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death Funeral 12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Ever in U.S. Race - American Indian, Black, White, etc. 11. Marital Statu 14. Race 2 should be filed within 72 hours after on and Mental Hygiene.
Is marked other than "natural", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No by Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 19a. Informant's Nam elationship (Type, Print) Health Item 27 all Secotive 20a. Method of Disposition

One of Disposition

Rurial 2 Commation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other Date permit. Pages 1
Department of H
Important: If Itel
any injury or oth 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ R
1 ☐ Donation 5 ☐ Other (Specify) -OS FOREST HII, MA 22. Name and Address of Eacility 21. Signatury of Funeral Service Licensee YORK RO. TIMONI UM MD 21093 sirigital PEAREFULALTERNATIVES FULERAR SICREMATION CRE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) castric Tue to (or as a consequence of): montas /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician 68760 Physician/Medical Box ( IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) Tyes 2 No P.O. 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 🚹 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 TYes 2 🗌 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of Certification: 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5830 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST PONSON NO wastes 660 W

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 3 2005

Concorno, Morther

32. Registrar's Signature

			1 - For State Registrar	State of Maryland /	Department of Health a Certificate of Death	nd Mental Hygie	01001 0000	
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	sseau D	eBloom	2. Date of Death Month	Pay 205 3. Time of Death	) M
	Examir Funeral		4a. Facility Name (If not institution, give s 5. Social Security Number 6. Sex	rd way AP+	4b. City, Town, or Location of Fundary 1 Year 1 Year 1 Hunder 2 Yrs. Months Days Hours		4¢. County of Death  4¢. County of Death  9. Birthplace (State or Fore)  County)	ign
	Director		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Location	#pr11-10,	10d. Inside City Limi	J_ its
	he Mary 28e-1 sho	ector	Maryland Harto	ord Be	lAir		1 □ Yes 2 🗹 N	
	ath with t	Funeral Director	1114 Van Gua	rd Way AP	+L 10f. Zip Code 21015	) 10g.	. Citizen of What Country?	
900	72 hours after death with the Maryland natural', or items 23e or 28e-1 show iteal Examerer must be routified at	by	11. Maritar Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ⊮No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 ☑ No Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.	
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	es 1 and 2 s of Health ar of tiem 27 le or other treu	THE ST	20a. Method of Disposition	Debloom 1	of Disposition (Name of ery, crematory or other place)	Way Be	c. Location City or Town, State	5
Baltimore,	permit. Pages Department of Importent: If it any injury or o	0 3	'4 □ Donation 5 □ Other (Specify)  21. Signature or Funeral Service License	5/4	22. Name and Address of Facility	2005 B	altimore Marylan I chapel - Beltin	nd
	Physician <sup>°</sup>	ii)	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition	rations that daused the death. Doe eause on each line.  Brain Ste	not enter the mode of dying, such as c	ardiac or respiratory arrest,	Approximate Interval Between Onset and Death Sik Week	/
	/Medical Examiner		resulting in death)  Sequentially list conditions	Due to (or as a consequence	e of):			
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	To the Hospitel or A within 24 hours after To the Funerel Directompletely filled in by	edical	29a. Certifier 1 Certifying Phys (Check only one)	icien: To the best of my knowledger: On the basis of examination a and manner stated.	pe, death occurred at the time, date and nd/or investigation, in my opinion, death	place, and due to the cause occurred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)	
ı	Vithi To the	Σ	29b. Signature and title of certifier	_	29c. License number		Date signed (Month, Day, Year)	
	11		30. Name any iddress of perso, who con	npleted cause of death (Item 23a)	(Type, Print)		sine or war	
	Sta	te	11. Date filed (Month, Day, Year) JUN 0 3 2005	Registrar's Signature	2-800; GOU NOM	Wolfe Street	June, 01 200 -, pallmore marginal	
	Registr	_	JUN 0 3 5002	Bloomer St. A	( Section )			

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		For State	State of	wai yiai i			of Death			Reg. No. 200	5 1861L
		Registrar  1. Decedent's Name (First, Middle, La	st)			imodio	0, 000		2. Date of Dea	ith	3. Time of Death
Physic		Abigail H. Deland	,						May 28	Day Year	5:00 A M
/Med Exami		4a. Facility Name (If not institution, giv		iber)		4b. City, To	own, or Location	of Death		4c. County of Dea	
		Calvert Manor Hea	lthcare	Center			ng Sun			Cecil	
Funera		Social Security Number     6. 5	ex □ M 2(X)F	7. Age (In yrs.		If Under 1 Months 1	Year If Under Days Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	r, Year) C	thplece (Stete or Foreign ountry)
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land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
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h the rr 28a rnotii	Director	10e. Street and Number				10f. Zip C	ode			10g. Citizen of Whal C	ountry?
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r dea	Funeral	11. Marital Status	12. Was Dece Armed For	ces?	.S. 13.	Was Deceder f Yes, specify	nt of Hispanic Or y Cuban, Mexicai	igin? (Spe n, Puerto l	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
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aryla should b and Ment	2	George Barrett							atkins	O'the Town Order	Ti- C-d-1
C 0 - 5		19a. Informant's Name/Relationship (								or, City or Town, State,	
		Evelyn Wood/Niece		20b. P	_ 6U8 J	ackson sition (Name	n School		1, UXIO	rd, PA 1936 20c. Location - City o	
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		21. Signature of Funeral Service Lice			norial 321 3	Name and	Address of Facili	in Card	ner Fu	neral Home	, 110
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/Medica Examine		resulting in death)		or as a conseq	uence of):			1 -			10
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BOX eath cert attendin for use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come of pregna irth 2 🗌 Feta		Ectopic pre	gnancy			23d. Date of de Month	Day Year
O. E he dea the at	Completed by Physician/Medi	in the past 12 months?  1 Yes 2 No 9 Unknown	4□Pregna 9□Unkno	ant at time of down	leath 5	Other (spec	city)				,
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Sio tendi feath. tor: A	catl	2 Accident investigation 3 Suicide 6 Could not	20	ad lainne. At h		M	1 Yes 2		29f Location (	Street and Number or F	Rural Route Number
Division of for attending Physical director: After this tin by the funeral director.	Certification:	4 Homicide determined	286. Place	of Injury - At h ng, elc. <i>(Speci</i> i	ome, rarm, st	reet, factory,	опісе		City or Tov		idiai node vainoei,
Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the tuneral director.		29a. Certifier 12 Certifying P	hysicien: To the	best of my kno	owledge, deat	h occurred at	t the time, date a	nd place,	and due to the	cause(s) and manner a	is stated.
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0		30. Name and address of person who					Rising	r Cun	Ма~тт1	and	
\ \		Joseph Wei						5 5411	, mary	.GILG	
Regis	tate trar	31. Date filed (Month, Day, Year)	0 3 4005	egistra s Signa	a St	1923	SU.				

		1- For Unpend Item 23a, 27, 28a-1 per me 6-6-05 tas G844 Certificate of Death  Reg. No. 2 0 5	18615
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  Diane  F  Deininger  2. Date of Death Month  Day Year  May 9, 2005  1	3. Time of Death  0:50 A
Funeral Director		Memorial Hospital     Cumberland     Allegany       5. Social Security Number     6. Sex     7. Age (In yrs. /ast birthday)     If Under 1 Year   If Under 24 Hrs.   8. Date of Birth   (Month) Day, Year)     9. Birthplate   19 min.   (Month) Day, Year)	ce (State or Foreig sylvania
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death with the	Funeral Director	10e. Street and Number  P.O. Box 575  10f. Zip Code 10g. Citizen of What Country 26719  USA  11. Marital Status  12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	
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Health a tem 27 is		Steven J. Deininger - Husband P.O. Box 575 Ft. Ashby, WV 26719  20a. Method of Disposition 1 Burial 2 Pacremation 3 Removal from State  1 Burial 2 Pacremation 3 Removal from State  1 December 1 Dece	
permit. Pages Department of Importent: If I any injury or o		'4 Donation 5 Other (Specify)  21. Signature of Fineral Service Licensee  22. Name and Address of Facility Leroy P. Wooster Funeral Home 441 White Horse Pike Atco, New Jersey	
Physician / Medical Examiner physician and the prival-transit	cal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last  Cause (Disease or impury that initiated events resulting in death) Last	iterval Between inset and Death
the death certification of the attending proceed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ Month Date of delivery	ıy Year
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hys this al dii	Certification; To B	examiner?  1 X Yes 2 No  Hospital: 1 Inpatient 2 X ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  5 -9 -05  M 1 Yes 2 X No  Subject ingested drug	
To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the		Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Rucky)  City or Town, State 0.0 Box 5  Mineral, W.Va.	575 
To the Ho within 24 F	Medical	29b. Signature and title of certifier  29c. License number  OCME  29d. Date signed (Month, Day  OCME)  29d. Date signed (Month, Day  OCME)	e cause(s)
Stat Registra	ě.	30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Penn Street Baltimore, Maryland :  31. Date filed (Month, Day, Year)  32. Registrar's Signature  JUN 0 3 2005	21201

			For State Registrar	State of Ma	aryland / Dep	ertificate of			giene	5 10616
	Dhysisi		1. Decedent's Name (First, Middle, Last,					2. Date of De	ath	3. Time of Death
	Physici /Medio		Charles F. Davis					June	2 20°	05 11:50 A <sup>M</sup>
	Examir	er	4a. Facility Name (If not institution, give				or Location of Death		4c. County of D	
			Hospice of Baltimo				If Under 24 Hrs.	T = - (5)	Baltimo	
	Funeral Director		219-14-2320 Usual Residence of Decedent	7. Ag	e (In yrs. last birthday 81 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Oct. 3	1923 M.	Birthplace (State or Foreign Country) aryland
	72 hours after death with the Maryland natural; or items 23a or 28a-f show acal Examilier in ust be notified at	ō	10a. State 10b. County MD Baltimore		10c. City, Town or L Baltimore	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	
	a with	Ö	8810 Walther Blvd.	Apt 161	10	21234			USA	Country
	death	Funerai		12. Was Decedent			Hispanic Origin? (Sp an, Mexican, Puerto			merican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or items any injury or other traumatic event, the Medical Examilies in 17-1008.	by Fur	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 X Yes 2 □ 1  If Yes, Give Year or Dates:	No	If Yes, specify Cub  1 ☐ Yes 2 ☑ No		Rican, etc.)	Specify:	/hite, etc.
9	2 hou		15. Decedent's Edu		16a, Dece	edent's Usual Occup	pation		16b. Kind of Busine	white
215	within 72 ene. than "ne ne Mcdil	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work done DO NOT use retire	during most of work d)	ing	TOD. KING OF BUSINE	samuustry
21	giene giene er tha	Com	12	4		otive Eng	ineer		CSX Rail	road
pu	be file tal Hy d oth	Be (	17. Father's Name (First, Middle, Last)					e (First, Middle,	Maiden Sumame)	
yla	ould b Ment Merkec	Tol	Granville Davis				Lillian	Pupp		
Maryland 21215-0036	nd 2 sh aith and 27 is m r traum		M. Doris Davis	<sub>рө, Print)</sub> / Wife	19b. Mail 8810	ing Address <i>(Str</i> eet Walther	and Number or Run Blvd. Apt	al Route Number	ar, City or Town, State Baltimore	e, Zip Code) , MD 21234
Baltimore,	Pages 1 a nent of Hea int: If item iry or othe		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □R	emoval from State	20b. Place of Disp cemetery, cre	osition (Name of omatory or other pla	се)	Date	20c. Location - City	
Ë	tmen tant: tant:		`4 ☐Donation 5 ☐ Other (Specify)		Parkwood			05	Parkville,	
Bal	Depa Depa Impo any ir		21. Signature of Furraral Service License	98		2. Name and Addre	n Funeral	Home	1050 Yor Towson,	°k Road MD 21204
Ę			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only of	/		A .				Approximate Interval Between
	Fry <del>sicia</del> n /Medical		Immediate Cause (Final disease or condition resulting in death)	Chro	mic o'	ostruct	we Lu	& dire	AS €	Onset and Death  years
Ŀ	Examiner		resulting in dealiny	Due to (or as	a consequence of):					0
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of):					
	uted d ansit	Examiner	Cause (Disease or injury that initiated events							
Ó,	cate be executed physician and the burial-transit	Exa	resulting in death) Last		a consequence of):					
8760,	ate be	dicai						_		
9	entific ding p	/Mec	IF FEMALE:	2- 16	,					
Box	eath certif attending for use as	ian/	in the past 12 months?	3c. If yes, outcome of the state of the stat	2 Fetal death 3	Ectopic pregnancy	1		23d. Date of o	delivery Day Year
P.O.	that the death cer ed by the attendir detached for use	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown	time of death 5 [	Other (specify)				
s, D	Attanding Physician: The law requires that the death certific r death. sctor: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as		Part II. Other significant conditions con				en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ğ	w require been signature should b	ted	ischemes CA	racom	2 but	7		1000	'es 2□No 3□	Probably 4 Unknown
Division of Vital Record	e law r has be ge 2 sh	Completed by	History of BLAdd	er Conce	ž C			24a. Was autop	an 24b. Were	autopsy findings available o completion of cause of
<u>~</u>	Physician: The la r this certificate has	Con	U					perfor	med? death	? es 2□ No
ĬĬ.	ician certifi ector	Be	25. Was case referred to medical examiner?	ospital:		011	26. Place of Death	_	/	- 11
ō	Phys r this ral dir	- To	1 ☐ Yes 2 No ''  27. Manner of Death	1   Inpatie		nt 3□ DOA Oth	er: 4 ☐ Nursing Ho	me 5 Resid	ence 6 Vether (Spow injury occurred	pecity) to spice
O	ding th. After fune	tion:	1 ♠ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury	Wor	yat k? Yes 2 □ No	zod. Describe n	ow injury occurred	50
S	Attandi r death. ector: A by the fu	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ury - At home, farm, st			28f. Location (S	treet and Number or	Rural Route Number.
á	s afte	Certificati	4 Homicide determined	building, etc	c. (Specify)			City or Tow	n, State)	
	To the Hospital or Attanding Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (	Check only 2 Medical Examin	er: On the basis of	of my knowledge, deat examination and/or in	h occurred at the tin vestigation, in my o	ne, date and place, a pinion, death occurre	and due to the o	ause(s) and manner date and place, and d	as stated. ue to the cause(s)
	ithin 2 o the omple	Med	one) 29b. Signature and title of certifier	and manner sta	ited.	29c. Licens			29d. Date signed (Mo	
	1 2 - 2		M Anthon	y Rule	J. mo					
1	otra	/	30. Name and address of person who con	( BMC	6701	Print) Al-Cha	ile St	Balt	Ture 2,	205)
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	1.1.				
	Registra	ar _	MW 0 3	2005	que B	GOVE				

DHMH 17 Rev 1/2001

			1- State of Maryland / Departm	ent of Health and Materials	lental Hygie	40115	1861
	Physica /Medi		Decedent's Name (First, Middle, Last)     Joseph Kelvin Duppen		2. Date of Death	Day 2005 Year	3. Time of Death 1:42 pm M
}	Examir			City, Town, or Location of Death		4c. County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	Innapolis nder 1 Year   If Under 24 Hrs.	8. Date of Birth	Anne Aru	ndel ace (State or Foreign try)
	Director		220-56-9140 1 M 2 F 50 Yrs. Mon	ths Days Hours Min.	(Month, Day, Ye July 11,	1954 Balt	imore, MD
	ryland		10a. State 10b. County 10c. City, Town or Location			11	Od. Inside City Limits
	the Ma	Director	MD Anne Arundel Annapolis  10e. Street and Number 10e.	7.01			t≯(\$Yes 2 □ No
	th with		810 Carrollton Avenue	21401		Citizen of What Coun Jnited Stat	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, if a Medical Evantriar must be retilified at once.	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Noivorced  12. Was Decedent Ever in U.S. Armed Forces?  1 17 Yes 2 17 Yes 1 1 1 1 Yes	ecedent of Hispanic Origin? (Spe specify Cuban, Mexican, Puerto l es ZUNo Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, 6 Specify:	etc.
Maryland 21215-0036	ithin 72 ho ne. nan "natur Medicel	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	Usual Occupation f work done during most of workin Truse retired)	ng 16b	. Kind of Business/Ind	
d 21	filed w Hygier other th	e Cor	11th Cook	18. Mother's Name	(First, Middle, Maid	Unemployed	l
ylan	Mental Mental Brkad c	To Be	Radner Duppen		cks	,	
Mar	d 2 sho th and ty is m traum			ress (Street and Number or Rura marak Blvd. Co		ty or Town, State, Zip Nio 43229	Code)
ore,	es 1 an of Heal ritem?		20a. Method of Disposition 20b. Place of Disposition	(Name of D		Location - City or Tov	vn, State
Baltimore,	t. Pag rtment rtent: i		Medi	cal School 5/27		lashington,	
Ba	Depa Impo any in	1	21. Signature of Funeral Service Licensee 22. Name	e and Address of Facility Au 3821	stin Roys! - 14th St.	ter Funera NW Washir	1 Home
			23a. Part 1. Enter the disease, obsemptications that caused the death. Do not enter the shock, or hear failure. List only one cause on each time.			2	Approxim20011
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Sequentially list conditions	AL FAVA	mino		Onset and Death
۱	Examiner		Sequentially list conditions, b.	IP ANTE	nyp	ISEASE	,
	uted I Insit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury	•			
ő,	icate be executed physician and the burial-transit	Exa	that initiated events c.  The sulting in death contains the contained by t				
68760,	ficate b physic s the b	edicai	d				
P.O. Box (	The law requires that the death certifi te has been signed by the attending i oage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death 3   Ectopi   4   Pregnant at time of death 5   Other	c pregnancy (specify)		23d. Date of deliver Month	y Day Year
	w requires that been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying	ig cause given in Part I.		o use contribute to the	
l Records,		Completed			24a. Was an autopsy performed 1 Yes 2 1	prior to com death?	sy findings available pletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death		10 100 1	
ō	g Physical this neral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at 2	ne 5 Residence 8d. Describe how in	6 Other (Specify) jury occurred	
Division	Attanding I or death. ector: After by the funer	catio	2 Accident investigation M	Work? 1 □ Yes 2 □ No			
<u>&gt;</u>	al or Attan after deatl Director: d in by the	Certification;	4 Homicide determined determined determined determined determined	tory, office 25	8f. Location (Street City or Town, Sta	and Number or Rural ate)	Route Number,
	To the Hospital or Att within 24 hours after d To the Funaral Direct completely filled in by I	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurr on the basis of examination and/or investigated and manner stated.	ed at the time, date and place, are ion, in my opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as sta and place, and due to t	red. he cause(s)
	To t To t	Σ	29b. Signature and title of certifier	29c. License number	-	Date signed (Month, D.	- '
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1) Clots	>	May 21, 20	ບວ
			Hector Collison, M.D. 1204 West Street	: Annapolis, MD	21401		
朔	Sta Registra		31. Date filed (Month, Day, Year)  JUN 0 3 2005				

DHMH 17 Rev 1/2001

Physic		Decedent's Name (First, Middle, I	.ast)			2. Date of Death	Day	3. Time of Deat			
/Med		Susan J.	DiSarro			MAY 30,	2005 Year	8:13 A			
Exami		4a. Facility Name (If not institution, g 900 CARPENTERS	POINT RD - LO	OT TS41	4b. City, Town, or Location of Dea CHARLES TOWN		4c. County of Death CECIL CO				
Funeral Director		5. Social Security Number 6. 152-46-9596  Usual Residence of Decedent	Sex 7. Age (In y	rs. last birthday, 50 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min	. (Month, Day, Ye	9. Birthp Coun	place (State or Fore htry) NJ			
how		10a. State 10b. County	10c.	City, Town or L	ocation		1	0d. Inside City Lin			
89-f	cto	PA Chest	er		Kennett Squa	are		1 XYes 2 □			
e or 2	Funeral Director	10e. Street and Number 520 Southview	Δνοημο		10f. Zip Code	10g.	. Citizen of What Cour	ntry?			
ms 23	era	11. Marital Status	12. Was Decedent Ever in	n U.S. 13.	Mas Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	USA 14. Race - Americ	an Indian.			
f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23e or 28e-f ehow other traumetic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	to Rican, etc.)	Black, White,	ite			
natr dice	Completed	15. Decedent's (Specify only highest of	Education grade completed)	16a. Dece (Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	orking 16I	b. Kind of Business/Ind	dustry			
than	m m	Elementary/Secondary (0-12)	College (1-4or 5+)		во мот use retired) Scopic Techniciar		Modiania	_			
Hygir other ent, p		17. Father's Name (First, Middle, La.	st)	LIIdo		ne (First, Middle, Mai	Medicine	9			
ind Mental F marked of umetic eve	To Be	Robert Gut	hridge		Barba	ara Mod	orhouse				
and l		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street and Number or R			Code)			
of Health item 27 r other tr		Donald W. DiSarro (spouse) 520 Southview Ave., Kennett Square, PA									
		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State									
든 문 글		'4 □Donation 5 □ Other (Spec	A .		Name and Address of Facility		idgeton Ne				
Depa Impo any ir		Mush	Atalle	-1)	3111 Mountain R		s Funeral I				
			220 to (01 43 4 00113	sequence of):							
oian and ourial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons  c. Due to (or as a cons	sequence of):							
r the attending physician and ched for use as the burial-transit	dical Examin	that initiated events	b. Due to (or as a cons	sequence of): sequence of): gnancy etal death 3 [	□Ectopic pregnancy □ Other (specify)		23d. Date of deliver	ry Day Year			
ed by the attending p detached for use as	Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a cons c. Due to (or as a cons d. 23c. If yes, outcome of pred 1 Live birth 2 Fr 4 Pregnant at time of 9 Unknown	sequence of):  gnancy etal death 3 [ of death 5 [	Other (specify)	23e. Did tobace		Day Year			
gned by the attending p be detached for use as	by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	b. Due to (or as a cons c. Due to (or as a cons d. 23c. If yes, outcome of pred 1 Live birth 2 Fr 4 Pregnant at time of 9 Unknown	sequence of):  gnancy etal death 3 [ of death 5 [	Other (specify)	23e. Did tobacc 1 ∐ Yes	Month co use contribute to the	Day Year			
e has been signed by the attending page 2 should be detached for use as	Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	b. Due to (or as a cons c. Due to (or as a cons d. 23c. If yes, outcome of pred 1 Live birth 2 Fr 4 Pregnant at time of 9 Unknown	sequence of):  gnancy etal death 3 [ of death 5 [	Other (specify)		Month  Co use contribute to the 2 No 3 Proba  24b. Were autoporior to complete death?	Day Year e cause of death? ably 4 Unknows			
certificate has been signed by the attending prector, page 2 should be detached for use as	Be Completed by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions	b. Due to (or as a cons c. Due to (or as a cons d. 23c. If yes, outcome of pred 1 Live birth 2 F 4 Pregnant at time o 9 Unknown contributing to death but not re	sequence of): gnancy etal death 3 [ of death 5 [ resulting in the u	Other (specify)	1 Yes  24a. Was an autopsy performed 1 Yes 2 ath (Check only one)	Month  co use contribute to the 2 No 3 Proba  24b. Were autoprior to comdeath? No 1 Yes	Day Year  e cause of death?  ably 4 Tunkno  sy findings availa  apletion of cause			
this certificate has been signed by the attending fat director, page 2 should be detached for use as	To Be Completed by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions	b. Due to (or as a cons c. Due to (or as a cons d. 23c. If yes, outcome of prec 1 Live birth 2 Fegnant at time of 9 Unknown contributing to death but not re Hospital: 1 Inpatient 2	gnancy etal death 3 f death 5 cresulting in the u	Other (specify)  nderlying cause given in Part I.  26. Place of Dea	1 Yes  24a. Was an autopsy performed 1 Yes 2 ath (Check only one)	Month  co use contribute to the 2 No 3 Proba  24b. Were autoportor to condeath? No 1 No 9 6 Other (Specify,	Day Year e cause of death? ably 4 Munkno pay findings availa apletion of cause 2 No SCENE			
 Atter this certificate has been signed by the attending p runeral director, page 2 should be detached for use as	To Be Completed by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1  Yes 2 No 27. Manner of Death 1  Natural 5  Pending 2  Accident investigati	b. Due to (or as a cons c. Due to (or as a cons d. 23c. If yes, outcome of precedent of the control of the cont	gnancy etal death 5 [ resulting in the u	26. Place of Deat 3 DOA Other: 4 Nursing H	1 Yes  24a. Was an autopsy performed 1 Yes 2 ath (Check only one)  tome 5 Residence	Month  co use contribute to the 2 No 3 Proba  24b. Were autoportor to condeath? No 1 No 9 6 Other (Specify,	Day Year e cause of death? ably 4 **Tunkno sy findings availa pletion of cause 2 **D No			
ath. rr: Atter this certificate has been signed by the attending p ie funeral director, page 2 should be detached for use as	Be Completed by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	b. Due to (or as a cons c. Due to (or as a cons d. 23c. If yes, outcome of pred 1   Live birth   2   Fr 4   Pregnant at time of 9   Unknown contributing to death but not re  Hospital: 1   Inpatient   2 28a. Date of Injury Format Day Year) be	grancy etal death 3 f death 5 cresulting in the u	26. Place of Deat 3 DOA  Other: 4 Nursing F  28c. Injury at Work?  A M 1 Yes 2 No eet, factory, office	24a. Was an autopsy performed 1 X Yes 2 ath (Check only one) dome 5 Residence 28d. Describe how in City or Town, S	Month  co use contribute to the 2 No 3 Proba  24b. Were autoportor to condeath? No 1 No 9 6 Other (Specify,	e cause of death?  ably 4 Tunkno  sy findings availa  pletion of cause  2 No  SCENE  nk			
ath. rr: Atter this certificate has been signed by the attending p ie funeral director, page 2 should be detached for use as	Certification; To Be Completed by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1  Natural 5 Pending investigate 2 Accident 3 Suicide 4 Homicide 1 Certifying F	b. Due to (or as a cons c. Due to (or as a cons d. 23c. If yes, outcome of pred 1   Live birth   2   Fr 4   Pregnant at time of 9   Unknown contributing to death but not re to be declared by the second by the second by the second by the second be declared by the second by the secon	gnancy etal death 5 [ resulting in the u  ER/Outpatier 28b. Time of Found 7:50 thome, farm, streacify)	26. Place of Deat 3 DOA  Other: 4 Nursing F  28c. Injury at Work?  A M 1 Yes 2 No eet, factory, office	24a. Was an autopsy performed 1 Yes 2 ath (Check only one) dome 5 Residence 28d. Describe how in City or Town, S Rd., Lot TS	Month  co use contribute to the 2 No 3 Proba  24b. Were autoportor to condeath? No 1 N Yes  6 N Other (Specify, njury occurred used)  (and Number of Rural (ate) 900 Carp.  41, Charles	e cause of death? e cause of death? ably 4 Munkno esy findings availa pletion of cause 2 No  SCENE  nk  Route Number P ton, Md			
ath. rr: Atter this certificate has been signed by the attending p ie funeral director, page 2 should be detached for use as	To Be Completed by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a cons  c. Due to (or as a cons  d. 23c. If yes, outcome of precaution of the construction of the constructio	gnancy etal death 5 [ resulting in the u  ER/Outpatier 28b. Time of Found 7:50 thome, farm, streacify)	26. Place of Dec.  26. Place of Dec.  1 3 DOA  28c. Injury at Work?  A M 1 Yes 2 No eet, factory, office	24a. Was an autopsy performed 1 1 Yes 2 1 ath (Check only one) dome 5 Residence 28d. Describe how in City or Town, S Rd., Lot TS.	Month  Co use contribute to the 2 No 3 Proba  24b. Were autoportor to condeath? No 1 Ness:  6 Nother (Specify, njury occurred uses)  (and Number or Rural (ate) 900 Carp.  41, Charles a(s) and manner as sta and place, and due to Date signed (Month, Date signed (Month) (M	Day Year  e cause of death?  ably 4 Junkno  asy findings availa apletion of cause of  2 No  SCENE  nk  Route Number P  ton, Md  ated. the cause(s)  Day, Year)			
 Atter this certificate has been signed by the attending p runeral director, page 2 should be detached for use as	edical Certification; To Be Completed by Physician/Medical Examin	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	b. Due to (or as a cons  c. Due to (or as a cons  d. 23c. If yes, outcome of precaution of the construction of the constructio	grancy etal death 3 [ for death 5 [ resulting in the u  ER/Outpatier 28b. Time of Formula 7:50 thome, farm, str crify)	26. Place of Dea 26. Place of Dea 28c. Injury at Work?  1	24a. Was an autopsy performed 1 1 Yes 2 1 ath (Check only one) dome 5 Residence 28d. Describe how in City or Town, S Rd., Lot TS.	Month  Co use contribute to the 2 No 3 Proba  24b. Were autoporior to condeath?  No 1 N Yes  6 N Other (Specify, njury occurred user)  At and Number of Rural atter)  41, Charles  e(s) and manner as sta and place, and due to	Day Year  e cause of death?  ably 4 Junkno  asy findings availa apletion of cause of  2 No  SCENE  nk  Route Number P  ton, Md  ated. the cause(s)  Day, Year)			

		-	For State Registrar	State of Marylan		ent of Hea			giene) (	005	18619
			Decedent's Name (First, Middle, Las	1)				2. Date of Dea			3. Time of Death
	Physicia		Edward	William	Eva.	n5		Month May	25	Year 05	1.35PM
	/Medic Examin		4a. Facility Name (If not institution, give			City, Town, or Lo	cation of Death	1100		inty of Death	
		eı	<u> </u>	a Medical	Center	Bali	timore	,			
	Funeral		0 0 1	7. Age (In yrs.	last birthday) If L		f Under 24 Hrs.	8. Date of Birth (Month, Day	h ( Year)	9. Birthp	place (State or Foreign
	Director		213-34-6646	<sup>M 2□ F</sup> 67	Yrs. Mor	iths Days I	Hours Min.	03/22		MD	y/
			Usual Residence of Decedent								
	ylan		10a. State 10b. County	10c. Cit	y, Town or Location						10d. Inside City Limits 1 Yes 2 □ No
	a-1 e	cto	MD Baltimon	ce City Bal	ltimore						
	or 28	Directo	10e. Street and Number		10	f. Zip Code			10g. Citizen	of What Cou	ntry?
	th wil		10 Light Street			21230				d Stat	
	dea	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. Was I	ecedent of Hispa specify Cuban,	anic Origin? (Sp. Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Ameri Black, White,	
٥	or It		1 Never Married 2 Married	1 Yes 2 □ No	1 🗆 Y	es 2 No	Specify:		Spe	ecify:	
5-0036	within 72 hours after death with the Maryland liene. Then "natural", or Items 23e or 28e-f ehow Ite Medical Exambact must be trollified at	d by	3 ☐ Widowed 4 Divorced	Year or Dates:					121 161 1	Whit	
ភ្នំ	72 h	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Decedent's	Usual Occupation of work done during the contract of the contr	on ing most of work	ing		of Business/Ir	idustry
2	Athin ne. hen.	d L	Elementary/Secondary (0-12)	College (1-4or 5+)		,			Unkno	WII	
Z		ပိ	17. Father's Name (First, Middle, Last)		Mechani		8. Mother's Name	e (First, Middle,	Maiden Sur	пате)	
ב	be filed tal Hyg od othe event,	Be		na In		'	Margaret			,	
3	should be and Mental marked o	္	William Henry Eva		10h Mailine Ad	dress (Street and			ar City or To	wn State Zi	n Code)
Maryland	C1 00 0		19a. Informant's Name/Relationship (7) Sandra Ferrer / Dat			th Shore					
	1 and Health em 27 ther ti		20a. Method of Disposition	9	Place of Disposition			Date Date		on - City or T	
0	Pages nent of h int: If ite iry or of		1 ☐ Burial 2 Cremation 3 ☐	Removal from State	cemetery, cremator	y or other place)		May 31			
<u>E</u>	tent:		`4 □Donation 5 □ Other (Specify		esapeake			2005	Belts	ville,	Maryland
Baltimore,	permit. Page Department Importent: Il any injury of once.		21. Signature of Funeral Service Licen	See		ne and Address nation an		l Alteri	natives	3	
	Physician /Medical		23a. Part Lenter the disease, or composition or heart failure. List only immediate Cause (Final disease or condition resulting in death)	blications that caused the deal one cause on each line.  a	th. Do not enter the			or respiratory ar		,,,,,,	Approximate Interval Between Onset and Death
-	Examiner		Sequentially list conditions,	b							1929
	D #	iner	if any, leading to immediate	Due to (or as a consec	quence of):						
, 60,	cate be executed physician and the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	quence of):						
687	phys phys s the	dlcal		. d							
Вох	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn    Live birth 2   Feta   Pregnant at time of 6	al death 3 Ecto	pic pregnancy er (specify)			23d	Date of delive	very Day Year
Р. О.	d by	Phy	Part II. Other significant conditions of	ontributing to death but not re-	sulting in the under	ving cause given	in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
rds,	quires the signer of signe		Pattil. Other significant conditions of	Onthibuting to death but not re-					Yes 2□N		1/
Ö	w rec	Completed						24a. Was		4b. Were aut	opsy findings available
Re	he lav e has	ЩC						autor perfo	omed/?	death?	ompletion of cause of
g	icien: Th certificate rector, pag		25. Was case referred to medical				26. Place of Deal			10,100	20.10
>	sicie cert irect	o Be	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other:		ome 5 Resi		Other (Spec	ifv)
o	Phys r this sral di	To :t	27. Mapner of Death	28a. Date of Injury	28b. Time of	28c. Injury a	ıt	28d. Describe			,,
on	ding th. Afte fune	tlor	1 ANatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work? 1 □ Ye	s 2 No				
Division of Vital Records,	To the Hospitel or Attending Physicien: The I within 24 hours after death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, f	actory, office		28f. Location ( City or To	Street and N wn, State)	umber or Ru	ral Route Number,
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysicien: To the best of my kn niner: On the basis of examin and manner stated.	owledge, death occ ation and/or investig	urred at the time gation, in my opin	, date and place, nion, death occur	, and due to the rred at the time,	cause(s) and date and pla	d manner as ace, and due	stated. to the cause(s)
	o the	₹	29b. Signature and title of certifier			29c. License r				igned (Month	
,	⊢ ≯ ⊢ ŏ		1 Ghando	MD		P17(	072		mo	14.2	5,2005
	121		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type Print	)	0	. 1	, , ,	1	- / -
	KII		E VOINE Fontan	1 1	===, (,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10 11	1. Green	1e 54,	reet	Balt	5,2005 Md-21201
	Sta	ate	31. Date filed (Month, Day, Year)	2. Registrar's Sign	lature Land					/	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year OOAN Evan **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Inmore USO 11 Cre If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 12M 20F 2 Yrs. 155-16-99 Director Usual Residence of Decede 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show other traumatic event. The Mudical Examiner must be notified at 1 Yes 2 No itimore MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number SA or items 23a 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Education College (1-4or 5+) Instructor and Mental Hygiene. s marked other than Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) should be f and Mental } 1 hackeras ast 19b. Mailing Address (Street and Number or Ruml Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 100/60KU1/8, MD 2/030 malcolm Vans 20c. Location wity or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of h Important: If ite any injury or of once. 2/2005 tovest Hill 1 Burial 2 Cremation 3 Removal from State 0 Evans funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pareful Alternatives Fureral tand 21. Sign yury of Funeral Service License permit. Timonium 2325 YUKK rd 23a. Part 1. Enter the disease, or come shock, or heart failure. List only of nat caused the deal . Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cell UniSi TIDAGL YEAR Priysician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of interpretational initiated events resulting in death) Last Due to (or as a consequence of): Examiner -transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medicai 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 TUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 21. No 1 Yes or Attanding Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Certification: To Be H-05/16 Hospital: 1 ☐ Inpatient Other: 6 Other (Specify) 1 🗌 Yes 3□ DOA 4 Nursing Home 5 Residence 2 No 2 ER/Outpatient 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death After Natural 5 ☐ Pending 1 Yes 2 □ No investigation 2 Accident completely filled in by the 281. Location (Street and Number or Rural Route Number, City or Town, State) Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and little of cartifier ause of death (Item 23a) (Type, Print) 6 BMC 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

@ 5:56 Am

1-9

EL ROS

Maryland 21215-0036

Baltimore,

P.O.

Records.

Division of Vital

2005

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			For	State of Maryland	d / Department of I		•	e regione.	
			1 Stata Ragistrar	41	Certificate of	Death	Reg. N	2005	18521
	Physic /Medi		1. Decedent's Name (First, Middle, L	GETT			2. Date of Death Month D 3	Year Year	3. Time of Death 5:04 PM
	Exami	ner	4a. Facility Name (If not institution, gi	ve street and number)	4b. City, Town, o	or Location of Death		c. County of Death	
	Funeral		1	Sex 7. Age (In yrs. Id		If Under 24 Hrs.	8. Date of Birth	OHU 1 1	pplace (State or Foreign untry)
	Director		032-40-1917 Usual Residence of Decedent	10 M 20 F 8	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea	WES	T VIRGINIA
	aryland show	_	10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits
	h the Marylan r 28a-f show	Funeral Directo	10e. Street and Number	IN	10f. Zip Code		100.0	Sisteman of Mallous Co.	1 🖫 ¥6s 2 🗆 No
	th with 23a or	al DI	4 LANDEIL	1. RD.	21010	00	1)4	Citizen of What Cou	STATES
	er dea	uner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was Decedent of H	Hispanic Origin? (Spean, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	ncan Indian,
036	aff of	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ ✔ To If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No	Specify:		Specify:	HITE
21215-0036		Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)	16a. Decedent's Usual Occup (Give kind of work done	during most of working	g 16b.	Kind of Business/I	ndustry
212	be filed within tal Hygiene. d other than "avent, I'm Mer.	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retire	9	E	nn st	SPVICE
pu	oe filed tal Hygi d other	Be C	17. Father's Name (First, Middle, Las	υ	VOI 1.1100	18. Mother's Name	(First, Middle, Maide		DEVICE.
Maryland		10	KUFUSS Q	DUINN	1	MINN	EW	HITE	
	nd 2 still ar ar 27 is		19a. Informant's Name/Relationship  CYNTHIA FUGE	TT/DAUGHTER	19b. Mailing Address (Street	4.0	AUTIMOR		ip Code)
altimore,	ges 1 and to the all the male in the male or other		20a. Method of Disposition 1 ☐ Burjal 2 ☐ Cremation 3 {	20b. Pl	ace of Disposition (Name of metery, crematory or other plan	сө)	te 20c. I	Location - City or T	
III m	t. Pa rtmer rtant:		'4 Donation 5 ☐ Other (Special Signature Fundament)	ANF		REG. 5/31	105 H	HOVE	R, MD
Ba	permi Depa Impo any is		V-1/20		22. Name and Addre	ss or Facility Family Funeral Hor Mountain Road -	ne And Cremation	Center, P.A.	
			224. Part1. Enter the disease, of our shock, or heart failure. List only	nplications that caused the death.	. Do not enter the mode of dyir	ng, such as cardiac or	respiratory arrest,	21122	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a LIVER CANCER					Onset and Death
ı	Examiner		Cognosticity list assertitions	Due to (or as a consequence)	ence of):				
/	per	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	ence of):				
oʻ	be executed iician and burial-transii	Exan	that initiated events resulting in death) Last	cDue to (or as a consequent	ence of):				
8760,	y s	dlcal		d					
Box 6	leath certificate attending physi I for use as the	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan				23d. Date of deliv	ren/
	0 0 0	Physician/Me	in the past 12 months? 1 ☐ Yes 2 🕱 No	1 □ Live birth 2 □ Fetal of dead of the limit of dead of the limit of		′		Month	Day Year
P.0	that the de ned by the a detached	/ Phy	9 ☐ Unknown  Part II. Other significant conditions		Iting in the underlying cause giv	en in Part I.	23e. Did tobacco	use contribute to:	the cause of death?
Records,	w requires that the been signed by the should be detached	ed by							bably 4XJUnknown
eco	as b	Completed					24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of
al B	Thate ate						performed? 1 ☐ Yes 2 🛣 No	death?	
Vital	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ▼ No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3 DOA Oth	er: 4 - Nursing Hom	(Check only one) e 5 ☐ Residence	6 T Other (Special	4.1 374 677 7
n of	ding Phys h. After this funeral di	on: T	27. Manner of Death 1   Natural 5 □ Pending		28b. Time of lojury Worl		d. Describe how inju		HOSPICE
Division	Attanding r death. actor: After	icatl	2 Accident investigation 3 Suicide 6 Could not be	De Diese et leive. At he	M 1 🗆	Yes 2 □ No	16 I 13 (Ctt	-14	10
Div	al or A s after it Dirac	Certification:	4 Homicide determined	building, etc. (Specify)	ne, farm, street, factory, office	28	3f. Location (Street a City or Town, Stat	nd Number or Huri в)	al Route Number,
	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Diractor: Atter th completely filled in by the funeral	edical C	29a. Certifier (Check only one)  (Check only one)  (Check only one)	nysician: To the best of my know miner: On the basis of examination	rledge, death occurred at the tin on and/or investigation, in my o	ne, date and place, an pinion, death occurred	d due to the cause(s I at the time, date an	.) and manner as s d place, and due t	stated. o the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and manner stated.	29c. License			ate signed (Month,	
	. 720		)		Du	13725	(	0/1/05	5
	1		30. Name and address of person who	•				-1.10-	-
	Sta	te	DR. TARIQ MAHMO( 31. Date filed (Month, Day, Year)	DD 2300 DULANEY  32. Remistrar's Signatu		LIMONIUM,	MD 21093		
	Registr		HIM O o	1,000	4 Late				

DHMH 17 Rev 1/2001

5:04 p.m.

MAY 31, 2005

DAISY FUGETT

			1- For Amend Item 19b per th 6845 / -28-05 tas Certificate of Death Registrar
	Physici	an	1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death
	/Medio	al	SXIRLEE FRIEDEMANN  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
	Examir	er	GOOD SAMARITAN HOSPITAL  BALTIMORE  N/A
L	Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) 86 Yrs. 86 Yrs. 1 Months Days Hours Min. 1 Days 1 Hours Min. 2 Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland
	wo wo		Usuel Residence of Decedent           10a. State         10b. County         10c. City, Town or Location         10d. Inside City Limits
	72 hours after deeth with the Marylend naturel', or Itams 23a or 28a-f show digel Examinar must be notified at	ctor	Maryland Baltimore Towson ¹□Yes 2\notin{No}
	with th	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	ns 23	erai	400 Hillen Road 21286 U.S.A.  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian,
9	or Itar		Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  Black, White, etc.
9	nours urel',	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates:  1 Yes 2 No Specify: Specify: White
5	in 72 in "nat	Completed	15. Decedent's Education (Specify only highest grade completed)  [Give kind of work done during most of working life. DO NOT use retired)  [Floratory (Constant (Const
212	d with giene.	mo.	Elementary/Secondary (0·12) College (1·4or5+)  12 Bookkeeper Automobile Dealer
nd	be file tal Hy d oth	To Be (	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)
$\frac{1}{2}$	hould d Men marka marka	ပ္	Joseph A. Friedemann  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of Bural Boute Number City of Town State, Zin Code)
Z	nd 2 sulth an 27 is i		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 30047  1393 Crooked Tree Court Lilburn, Georgia 30847
Baltimore, Maryland 21215-0036	of Head of Hea		20a. Method of Disposition  20b. Place of Disposition (Name of Date 20c. Location - City or Town, State
Ē	Pages Iment of h tent: It Its		'4 Donation 5 □Other (Specify) Druid Ridge Cemetery 6-4-2005 Pikesville Maryland
Ball	permit. Pages 1 and 2 should be ified within 72 hours after deeth with the Marylen Department of Health and Mental Hygiene. Importent: It tiem 27 is marked other than "naturel", or itams 23s or 28a-f show any injury or other treumatic event, the Mydical Examinar must be notified at once.		21. Signature Thera Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204
S	Pnysician <sub>1</sub>		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death disease or condition
	/Medical Examiner		Due to (or as a consequence of):
	2003	e	Sequentially list conditions, if any, leading to immediate cause filterations.  Due to (or as a consequence of):  ECRN (Following Consequence):
	cuted hd ransit	Examiner	that initiated events
8760,	icate be executed physician and s the burial-transit	EX	resulting in death) Last  Due to (or as a consequence of):
687	physical phy	dical	d
Box	death certificate be executed e attending physician and of for use as the burial-transit	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery
o	t the deatl by the atte ached for	Physician/Med	in the past 12 months?  1
rds, P.	law requires that the de as been signed by the 2 should be detached	ò	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Qunknown
<b>6</b> 00	law re as bed	Completed	AORTIC STENOSIS  24a. Was an autopsy findings available prior to completion of cause of
<u>~</u>	Physician: The lav this certificate has al director, page 2	Con	DIABETES MELLITIS 1 Yes 2 No 1 Yes 2 No
<u> </u>	sician certifi irector	Be c	25. Was case referred to medical examiner?  1 Tyes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specific)
Division of Vital Record	Hospitel or Attending Physician: 24 hours after death. Funeral Director: After this certificially filled in by the funeral director.	on: To	27. Manner of Death 1
isic	Attend death ctor: y the f	ertification:	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined determined  28e. Place of Injury. At home, farm, street, factory, office  28f. Location (Street and Number or Rural Route Number,
á	s after s after al Dire	Certi	4 Homicide building, etc. (Specify)
	To the Hospitel within 24 hours a To the Funeral C completely filled	edical (	29a. Certifier (Check only one)  1. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2. Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the within 2 To the complet	ž	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
			▶ Jania Januka   RES-000 5 31 2005.
1	11		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TANIA LAMBA, 560) LOCK RAVEN BLVD, BALTIMORE, MD ZIZ39
1	Sta Registra	9 1	31. Date filed (Month, Day, Year)  32. Registrar's agnature  2005

			Pleas	se Type or Pri								•	
			For State	State of M	larylan					Menta	-	00000	10000
		_	Registrer  1. Decedent's Name (First, Middle	(ast)		Ce	runca	ite or	Death	2 Date	Reg. I	40. [ ] j	3. Time of Death
	Physici	an			rloir	201				Mon	ith E	O 2003	
	/Medio Examir		4a. Facility Name (If not institution			103	4b. Ci	ty, Town, o	r Location of De			4c. County of Dea	
Н	LAGIIII		North Aru	ndel Hos	pit	41	6	len	Burni	e		Anne	Arundel
	Funeral		5. Social Security Number			last birthday,	If Und Month	der 1 Year s Days	If Under 24 H Hours Mi		of Birth oth, Day, Yea	9. Bir	thplace (State or Foreign ountry)
	Director		227-36-8575 Usual Residence of Decedent		/	73 Yrs.	<u></u>			Aug	. 31 1	931	VA
	/land		10a. State 10b. County		10c. Cit	y, Town or L	ocation						10d. Inside City Limits
	e-fet	ctor	Maryland Anne	Arundel				Gle	en Burni	e			1 ☐ Yes 2 ☒ No
	ith the	Olre	10e. Street and Number	•			10f.	Zip Code	04064		10g. (	Citizen of What C	-
	s 23a	Funeral Director	6515 Pampano D	12. Was Decedent	- Francis II	6 12	Was Da		21061	(Casaila Vas	as No.	14. Race - Am	
	item Item	nu	11. Marital Status 1 ☐ Never Married 2 ☑ Marri	Armed Forces	?	.5.	tf Yes, s	pecify Cuba	lispanic Origin? an, Mexican, Pue	erto Rican, e	tc.)	Black, Whi	te, etc.
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene.  d other than "natural", or items 23a or 28a-f ahow event, the Medical Examination in all fed at	þ	3 ☐ Widowed 4 ☐ Divorced	ed 1 Tyyes 2 If Yes, Give Year or Dates:			1 🗆 Yes	2 No	Specify:			Specify: W	nite
2-0	72 ho	eted	15. Decedent (Specify only highes			(Give	kind of	sual Occup work done	during most of w	orking	16b.	Kind of Business	/Industry
7	within ne. han	mp	Elementary/Secondary (0-12)	College (1-4or	5+)			ic En	gineer		10	lestingho	AZIC
2	filed v Hygie other t	ပ္သို	12 17. Father's Name (First, Middle, I			LIEC	CI OII	IC LII	18. Mother's N	ame (First, I			Juse
an	ild be lental rked c	To Be Completed	Oscar Ander	son Forl	oines	5			Nelli	e M	ae	Crawford	t
ary	2 should and Men Is marke aumatic		19a. Informant's Name/Relations		,							y or Town, State,	
Σ (`	and 2 ealth m 27 I		Dorothy F. Forl	oines (spou				•	Drive,			, MD 210	
Ore	Pages 1 nent of H int: If itel iry or oth		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation			tace of Disponentery, cre	matory o	r other plac	· IMa	y 31		Location - City or	
Baltimore,			<ul> <li>4 □ Donation 5 □ Other (S<sub>k</sub></li> <li>21. Signature of Funeral Service)</li> </ul>		IME	tro Cr			ss of Facility	2005			Maryland
Ba	permit. Departr Importu any inji		Mustell	Atologo	. ~	1			-			Funeral a, MD 21	Home, P.A.
П	14 50		23a. Parl 1. Enter the disease, or shock, or heart failure. List	complications that cause	d the deat							X 9 11D C1	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	\$77	ROK	5							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	s a conseq		4						4 2
	Lammer	J.	Sequentially list conditions, if any, leading to immediate	b. CARO Due to (or as	TZO		ART	ENEC	TOMY				6 DA 75
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	200 10 (01 43	, a conseq	301100 01).							
o,	be executed ician and burial-transit	Еха	that initiated events resulting in death) Last	C Due to (or as	s a conseq	uence of):							
3760		Ical		d									
x 687	The law requires that the death certificate to the has been signed by the attending physic age 2 should be detached for use as the b	Physician/Medical	tF FEMALE:	00- 1/	4								
Box	attenc for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant a	2 Feta	Ideath 3	⊒Ectopic ⊒ Other	pregnancy	′			23d. Date of de Month	livery Day Year
o.	at the de by the a	yslo	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	it time or d	5001		specify/					
ď.	res that igned b be deta	by Pl	Part II. Other significant condition	ns contributing to death I	but not res	ulting in the a	underlying	g ca <i>u</i> se giv	en in Part I.	23e	. Did tobacco	o use contribute to	o the cause of death?
Vital Records,	w require been sig should b										1 Nes	2 □ No 3 □ P	robably 4 Unknown
ecc	e law re has be je 2 sh	Completed								24a	. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
		Con								10	performed? Yes 2	death? 1 ☐ Yes	2 10
Z Z	hysician: The la his certificate has I director, page 2	Be	25. Was case referred to medical examiner?	Hospital:	/			Oth	26. Place of D				
	Physic this stal dis	To :	1 Yes 2 No 27. Manner of Death	28a. Date of thi	ury	ER/Outpatie		28c. tnjur Wor	4 🗆 I TUI SIII I G			6 ☐Other (Spe jury occurred	ocify)
on	Attending Physician: r death. ector: After this certifici by the funeral director,	atior	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investig		ay Year)	tnjury	М		k? Yes 2 □ No				
Division of	r Atte er dea recto	Certification:	3 Suicide 6 Could r 4 Homicide determi		itury - At ho	ome, farm, st	reet, fact	ory, office		28f. Loca City	tion (Street or Town, Sta	and Number or R	ural Route Number,
	oital or A												
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying (Check only 2 Medicel I	g Physicien: To the best Examiner: On the basis of and manner si	of examina	wledge, deat tion and/or in	th occurre ivestigati	ed at the tir on, in my o	ne, date and pla pinion, death oc	ce, and due curred at the	to the cause time, date a	(s) and manner as ind place, and due	s stated. e to the cause(s)
	To the Within 7 To the comple	Med	29b. Signature and title_of certifier		tutou.		2	29c. Licens	e number		29d. C	ate signed (Mont	h, Day, Year)
	F > F 0		· With	LIME	2			D 00	060796	,	3	-30-	2005
1	11		30. Name and address of person	who completed cause of	death (Iten	п 23а) (Туре,	Print)	- 10	<i>(/</i>			. /-	2005 1ARYLAND
4	)   '		(JICAAM) 31. Date filed (Month, Day, Year)	HIN N	WATI	H AR	JNL	DEL 1	MIRITALUM	74 6L	EN CUI	RNIEN	ARYLAND
	Sta Registr		JUN 0 3 20	32. Regist		5,00	Ke !						

				State of Maryland				•	-	
			1 - For State Registrar	olato of maryland		rtificate of			2005	18624
	Dhysia	ion	1. Decedent's Name (First, Middle, Last,	)				2. Date of Deat	h _	3. Time of Death
	Physic /Med	cal	James Larry Gilb					June 1,	2005 Yea	5:20 A <sup>M</sup>
4	Exami	ner	4a. Facility Name (If not institution, give	street and number)			or Location of Death		4c. County of De	
		_	205 Glider Drive  5. Social Security Number 6. Secu	7. Age (In yrs. las	t hirthday)	Middle If Under 1 Year		R Date of Righ	Baltimo	
	Funeral Director			<sup>M</sup> <sup>2□</sup> F 62	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Jan. 19, 1		Birthplace (State or Foreign Country)
	pu ,		Usual Residence of Decedent					barr. 15,	743 [161	1165566
	laryia shov	5	10a. State 10b. County		Town or Lo					10d. Inside City Limits 1 ☐ Yes 2,5(No
	28a-f	Director	Maryland Baltimore	e Mic	ldle I	10f. Zip Code		11	g. Citizen of What	
	h with		205 Glider Drive			21220	)		U.S.A.	Country
	deat	ner		12. Was Decedent Ever in U.S. Armed Forces?	13.		Hispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No-	14. Race - Ar	nerican Indian,
36	or It	by Funeral	1 Never Married 2 Married	1√274es 2 □ No 196 If Yes, Give 106	2	ires, specily cub 1 □ Yes 2 🕱 No		nican, etc.)	Specify:	
Ö	d within 72 hours after death with the Maryland jiene. rrthan "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at	ed b	3 Widowed 4 Divorced	Year or Dates:						White
215	nin 72 in "na Wedig	plet	(Specify only highest grade	completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of worki d)	ng 1	6b. Kind of Busines	ss/Industry
2		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Cont	tractor			Trucking	7
nd	d d d	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M	laiden Sumame)	
Maryland 21215-0036		P.	Brown Gilbert				Iva DeP			
Ma	01 (2) 01	T. C.	19a. Informant's Name/Relationship (Ty) Evelyn Gilbert (Wif				and Number or Rura			
ē,	s 1 and 2 if Health itam 27 I	H	20a. Method of Disposition	20b. Plac	e of Dispo	sition (Name of			Oc. Location - City	
E	Pages nent of int: If it iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ R  `4 ☐ Donation 5 ☐ Other (Specify)	dilioval livili State		natory or other pla Of Faith	June 4	.2005 F	altimore.	Maryland
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Full and Savy Cicense				ess of Eacility Tuzdzinski			
	20 = 29		12			40/ OIG	Eastern A	venue, E	ssex, Mar	yland 21221
П			silven, or fleatt failure. List only on	cations that caused the death.	Do not ent	er the mode of dyir	ng, such as cardiac o	r respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Metasta	he	Pano	readic C	ance	1	8 months
	Examiner			Due to (or as a consequer	nce of):					
	п =	ner	Sequentially list conditions, if any leading to the class cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequer	rea off):					
V	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
760,	icate be executed physician and s the burial-transit	calE	and the same of th	Due to (or as a consequer	ice of):					7
687	ficate physics the		d							
Box	h certi anding use a	M/U	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnance					23d. Date of de	elivery
B	that the death certifical ed by the attending phydelached for use as the	Physiclan/Med	in the past 12 months? 1 \( \subseteq \text{Yes}  2 \subseteq \text{No} \)	1□Live birth 2 □ Fetal de 4□ Pregnant at time of deat 9□ Unknown		Ectopic pregnancy Other (s <i>pecify)</i>	·		Month	Day Year
P.O.	at the d by tl etach	Phy	9 Unknown							
ds,	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as th	by	Part II. Other significant conditions con	thouting to death but not resulting	ng in the un	iderlying cause giv	en in Part I.	23e. Did toba		to the cause of death?  Probably 4 □Unknown
COL	w requ	lete						-		
Re	sician: The law s certificate has b lirector, page 2 s	Completed						24a. Was an autopsy performs	prior to	
		0	25. Was case referred to medical				26. Place of Death			s 2 No
	Attending Physician: The r death. ector: After this certificate he by the funeral director, page	To B	examiner? 1 Tyes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER	/Outpatient	3 DOA Oth	20		ce 6 □Other (Sp	ecify)
Division of	ding Phys h. After this funeral di	on:	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28	b. Time of Injury	28c. Injun Worl	k?	8d. Pescribe how	injury occurred	
Sign		icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home	form stra		Yes 2 □No	96 Leastine (Ctue	-4	
<u>&gt;</u>	after after Direction	Certification:	4 Homicide determined	building, etc. (Specify)	, iaiii, stie	et, ractory, office	2	City or Town,	et and Number of F State)	Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	alc	29a. Certifier 1 Certifying Physi	cian: To the best of my knowle	dge, death	occurred at the tin	ne, date and place, a	nd due to the cau	se(s) and manner a	s stated.
	the Hin 24 the Fu	ledical		er: On the basis of examination and manner stated.	and/or inv	estigation, in my o	pinion, death occurre	d at the time, date	and place, and du	e to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of perlifter			29c. License	e number		Date signed (Mon	
	OVI		The second	asallah	NM	V DA	>>30	(	16 - 2 -	2005
	da,		30. Name and address of person who con	npieted cause of death (Item 23		erint) and pl	Del Con	200	Juile 211	2005 1MD21236
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signature			Jan Cay	ce j.		1 10 21030
	Registr	ar	JUN 0 3 2005	Elever It	Goes	W				

			1 - For State Registrar	State of	Maryland		artmen rtificate				lental Hyg	jiene leg. No.	005	186	525
	Physici	an	Decedent's Name (First, Middle	o, Last)							2. Date of Dea Month	th Day	Year	3. Time o	
	/Media	cal	Grace Smith Gil  4a. Facility Name (If not institution		er)		4h Cih	Town or	Location of	of Dooth	June	1, 20	05 unty of Death		PM M
	Examir	ier	7998-G Silent				40. City,		Glen		ie		e Arur		
	Funeral		5. Social Security Number		Age (In yrs. las	it birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birth (Month, Day			place (State intry)	or Foreign
	Director		484-12-4015	1□ M 2√F	86	Yrs.	Months	Days	Hours	Min.	06/05/		GA	intry)	
	and and		Usual Residence of Decedent  10a. State 10b. County		10c, City,	Town or Lo	cation							10d. Inside C	City Limits
	Many if she	tōr	MD Anne	Arundel	Gler	ı Bur	nie								2 □ No
	th the	Director	10e. Street and Number			. Dul	10f. Zip	Code				0g. Citizen	of What Cou	intry?	
	23a c	ralD	7998-G Silent N	Vinds Court	·		210	061				Unite	d Sta	tes	
	er deg	Funeral	11. Marital Status	12. Was Decede Armed Force	es?	13. \	Was Deced	ent of Hi	spanic Ori n, Mexicar	gin? (Spe	cify Yes or No- Rican, etc.)		Race - Amer Black, White		
36	irs aft	by F	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☑ Divorced	led 1 ☐ Yes 2 If Yes, Give Year or Date			1□Yes :	2 № No	Specify:			Sp	ecify: Bla	a le	
21215-0036	72 hours after death with the Maryland natural', or items 23a or 28e-f show dired Examiner must be incitified at		15. Decedent	's Education		16a. Deced	dent's Usua	I Occupa	ition			16b. Kind o	of Business/Ir		
215	within 7 iene. than "n	ompleted	(Specify only highes Elementary/Secondary (0-12)	College (1-4	or 5+)	life. I	kind of wor DO NOT us	k done d e retired,	uring mos	t of worki	ng	Treas	sury De	epartm	ent
121	filed w Hygier other th	O	17. Father's Name (First, Middle,	10-11	_3	Secui	rities	s Exa							
anc	ould be fi Mentat H arked ot atic ever	Be.	Charles Wesley								(First, Middle, Taylor	Maiden Sur	пате)		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Manylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28e-f show or other treumatic event. The Medical Examiner is using the mollified at	ပ	19a. Informant's Name/Relations			19b. Mailin	ng Address	(Street a			l Route Number	. City or To	wn. State. Zi	n Code)	
	l and 2 lealth a im 27 ls her trei		Gloria Gibson /	daughter	1						nie, MD			,	
ore	of He of He fiterr		20a. Method of Disposition 1 □ Burial 2 □ Cremation	3  Pemoval from Str		e of Dispo	sition (Nam	ne of ther place	9)		Jun 5	20c. Locati	on - City or T	own, State	
Baltimore,	Pages Iment of I tent: If its jury or o		`4 □Donation 5 □ Other (S <sub>i</sub>			sapea	ke Cr	emat	ory		2005	Belts	ville,	Maryla	ınd
Bai	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service					ion a	and Fu	inera	l Altern				
			23a. Part1. Enter the disease, or	2010000	<i>N 003 &amp;2</i> sed the death.		8717 G er the mode	reen	Pasti	ures cardiac o	Drive E	Baltim est	ore, Ma	aryland Approxima	
	Pnysician /Medical		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a.adva	n line.		(7)						se	Interval Ber Onset and	ween
	Examiner		, , , , , , , , , , , , , , , , , , , ,	Due to (or	as a consequer	nce of):	)							1	
		Jer	Sequentially list conditions, if any, leading to immediate	b. — Due to (or	as a consequer	nce of):									
	cate be executed bhysician and the burial-transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	c										_	
8760,	oe execian a		resulting in death) Last	Due to (or	as a consequer	nce of):									
387	physicate by sthe k	dice		d											
Box 6	death certific e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor								23d	Date of deliv	arv	
		icia	in the past 12 months? 1 🗆 Yes 2 X No	4 Pregnant	2 Fetel de t at time of deat		Ectopic pre Other (spe					1 233.	Month	•	Year
P.0	that the deatt ed by the atte detached for	hys	9 ∐Unknown ▼	9L Unknow											
	Se Un e		Part II. Other significant condition	ns contributing to death	h but not resultir	ng in the ur	nderlying ca	iuse give	n in Part I.	4 C	_	-	contribute to t		
Ö	w require been si should I	eted	Cysphagia,	CANO	10101	<u></u>	مر د	aci	21/	ربا	1 🗆 Ye				Jnknown
Rec	The law ite has b	Completed by	Wice 25								24a. Was a autops perforr	y	lb. Were auto prior to co death?	psy findings mpletion of c	available ause of
ta		e Co	25. Was case referred to medical					<del></del>	OC Place	of Dooth	1 ☐ Yes	No		2 No	
<u> </u>	Physician: this certific ral director,	0 B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpa	atient 2 ☐ ER	/Outpatien	t 3 DO	Othe	-	rsing Hon	(Check only on ne 5 Reside		Other (Specia	(v)	
n 0	ng Ph fter th nerai	Du: T	27. Manner of eath 1 Natural 5 ☐ Pending	28a. Date of In	njury 28 Day Year)	b. Time of		Bc. Injury Work			8d. Describe ho		, ,	,	
Sio	ttendii death. stor: A	catle	2 Accident investig	ation of he			М	1 🗆 Y	es 2 🗆 t						
Division of Vital Records,	I or Attending latter death. Director: After in by the funer	Certification:	4 Homicide determi	ned 286. Place of	Injury - At home etc. (Specify)	e, farm, stre	et, factory,	office		2	8f. Location (St. City or Town	reet and Nu , State)	mber or Run	d Route Num	ber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifyin:	g Physicien: To the be	st of my knowle	dge, death	occurred a	it the time	e, date and	d place, a	nd due to the ca	iuse(s) and	manner as s	tated.	
	To the H within 24 To the Fi complete	Medical	one)	xaminer: On the basis and manner	stated.	and/or inv									
<b>.</b>	Viii To	=	29b. Signature and title of certifier	in		_		License		9	29	d. Date sig	ned (Month,	Uay, Year)	
,	h /		30 Name and address of person v	vho completed cause o	f death (Item 23	Ral (Tunn 1	Print\		V 7/	73	May #	6	ined (Month, -/-O	7	
	)		Celecca (	ElonM	086	O/V	eter	ans	SK	hu	rous #	MA	len	11/10	MD
•	Sta	te	31. Date filed (Month, Day, Year)	3 2005 32. Ref	strar's Signature	b 1	pode	1	/	,,,,,	1		,	211	00
	Registr	ar	JUN U	2 5000							V				-

			For Stata Registrar		State o	f Marylan	•	rtment of H		lental Hygier	71111	18626
П			Decedent's Name (Fire	st, Middle, Lasi	)					2. Date of Death		3. Time of Death
	Physicia /Medic		William Ok							Month 2	200 <u>°</u>	5 1151p M
	Examin		4a. Facility Name (If not					•	Location of Death		4c. County of D	
			Harford Me			7. Age (In yrs.	lost hirthdow		De Grace	9. Date of Righ	Harfor	
	Funeral Director		5. Social Security Number 039-50-251	44	X ]M 2□F	67	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye. 11-22-19	37	Birthplace (State or Foreign Country) Ghana
			Usual Residence of Dec	edent								
	how	_		. County	1		, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	Ba-fs	cto	MD	Hartfo	ra	A	berdee					
	with ti		10e. Street and Number 210 Hiobs	Lano				10f. Zip Code	1001	Tog.	Citizen of What Ghana	Country?
	death with the Maryland ms 23a or 28a-f show rmst be redfilled at	Funeral Director	11. Marital Status	Dane	12. Was Dec	edent Ever in U.	S. 13. V	1		ecify Yes or No-		American Indian,
20	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene and Mental Hygiene la marked other than "natural", or items 23a or 28a-1 show tamatic event, the Medical Examiner must be rediffed at	by Fun	1 Never Married		Armed Fo 1 ☐ Yes If Yes, Gi	2∱∑No ve		Yes, specify Cuba  ☐ Yes 25000000000000000000000000000000000000	ispanic Origin? (Spi n, Mexican, Puerto Specify:	Rican, etc.)	Black, V Specify:	Vhite, etc. Black
9500-6121	hour tural			Decedent's Edi	Year or D	vates:	16a. Deced	lent's Usual Occupa	ation	16b	. Kind of Busine	ass/Industry
ÿ	n "na	Completed	(Specify or	nly highest grad	le completed)	1 407 F : \	(Give	kind of work done of NOT use retired	during most of work.	ing	, rema or busine	od madety
7	d with	mo	Elementary/Secondar	y (0-12)	College (	1-401 5+)	Flia	ght Contr	oller		Airline	es
<u> </u>	al Hys	Be C	17. Father's Name (First							(First, Middle, Maio		
yland	Ments Ments arkec	To I	William Ga							Abla Binka		
Mar	nd 2 sho lith and 27 la m r traum		19a. Informant's Name/ Winston O.		урв, Print) (son)					en MD 210		te, Zip Code)
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic a <u>pnce</u> .		20a. Method of Dispositi 1 ⊠Burial 2 □ Cr	emation 3 🗆		State Ge	lace of Disposementery, cremoners	sition (Name of natory or other place ashington	e)		40-0000	or Town, State
	artmer artmer ortant injury		' 4 ☐ Donation 5 ☐ 21. Signature of Funera			Me	norial	Park Name and Addres	06-0	04-2005	Adelphi	. MO
g	Deport any any	ı	> Strate	LAK	Laure .	14603	32	Rann Fun	eral & Ci	remation S ver Spring	ervice	210
	_		23a. Part 1. Enter the di	sease, or comp	lications that	caused the deat	n. Do not ente				THE 203	Approximate Interval Between
	Pnysician		shock, or heart fail Immediate Cause (Fina disease or condition resulting in death)			1	rebr	al Hen	norrha	je		Onset and Death 3 olays
	/Medical Examiner		resulting in death)		Due to	(or as a conseq	uence of):	Sian		U		514420
i.		Į.	Sequentially list condition	equentially list conditions, any, leading to immediate Due to (or as a ordisequent use. Enter Underlying ause (Disease or injury								210 913
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injurithat initiated events	g y								
oʻ	death certificate be executed eattending physicien and burial-transit of for use as the burial-transit		resulting in death) Last	- 1	Due to	(or as a conseq	uence of):					
9/9	ate be nysicie he bu	dical			d							<u> </u>
Õ	entificating ph	Med	IF FEMALE:									
ROX	leath certific attending p	Physiclan/Me	23b. Was decedent pre in the past 12 mon	gnanı į	1 ☐Live i	tcome of pregna birth 2 Feta	Ideath 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
	he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unkn	nant at time of d lown	eaui 5	Other (specify)				
٦.	The law requires that the de ate has been signed by the a page 2 should be detached f		Part II. Other significan	t conditions co	ontributing to d	leath but not res	ulting in the ur	nderlying cause give	en in Part I.	23e. Did tobacc	o use contribut	e to the cause of death?
<u>S</u>	quires n sign ald be	d by								1 🗆 Yes	2 No 3	Probably 4 Unknown
Vital Records,	sw requir s been si should I	Completed								24a. Was an	24b. Were	autopsy findings available
He	The la	mo			-			-		autopsy performed 1 Yes 2 2	? deat	to completion of cause of h? Yes 2 \sum No
Ita		Bec	25. Was case referred t examiner?	o medical					26. Place of Deat	h (Check only one)		
	physic this ce al dire	To	1 ☐ Yes 2 ☑ No				ER/Outpatien		4   Nursing no	me 5 Residence		Specify)
ם	ding Ph h. After th funeral	on:	27. Manner of Death  1 Natural 5	Pending		of Injury oth, Day Year)	28b. Time of Injury	Wor	k?	28d. Describe how in	njury occurred	
<u>s</u>	Mtendi death. ctor: A y the fu	icati	2 ☐ Accident 3 ☐ Suicide 6	investigation  Could not be	-	o of Injuny - At h	ama farm str	M 1 D	Yes 2 □ No	28f Location (Street	and Number o	r Rural Route Number,
Division of	of or Attendated after death Director:	Certification:	4  Homicide	determined	build	ling, etc. (Specif	y)	eet, factory, office		City or Town, S		Tigle Tigle Teather,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical C			iner: On the b					and due to the cause red at the time, date		
	o the	Med	29b. Signature and title	of certifier				29c. Licens	e number	29d.	Date signed (M	Ionth, Day, Year)
	->-0		> 1607	Tiam		MD		D :	32609	5	29/0	
	b		30. Name and address	of person who	completed cau	se of death (Iter	106 Re	Print)	1 3+-H	wre De G	race M	1 21072
	Sta Regist		31. Date filed (Month, D	Day, Year)	15	Registrar's Sign	ture	de)				1 21073
	ricgist	النه	IUI.	1 0 9 50	100		- 6					

			1 - For State Registrar	State of Maryl	-	ertificate			Hygier Reg. N	en	E 10000
	Physici /Medic Examin	cal	1. Decedent's Name (First, Middle, Last	MM ER	entei	1	m, or Location o	5 Wont		Day Ye	50455A M
l	Funeral Director		2.0 0. 3302	x 7. Age (In )	rs. last birthda 67 Yrs.	Months Da	ear If Under	Min. 8. Date (Mon	of Birth th, Day, Yea 1 18, 1	9.938	Birthplace (State or Foreign Country) PA.
	ne Maryland 8a-f show	ector	Usual Residence of Decedent  10a. State 10b. County  MD. Baltimor		City, Town or Edgeme	re					10d. Inside City Limits 1 ☐ Yes 2 No
	h with t	al Dire	10e. Street and Number 7956 Shore Road			10f. Zip Coo 21	1219		-	Citizen of Wha USA	t Country?
920	be filed within 72 hours after death with the Maryland ttal Hygiene. Id other than "natural", or Items 23a or 28a-1 show event, the Medical Examiran relative rigitlist at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No lf Yes, Give Year or Dates:	n U.S. 13	. Was Decedent If Yes, specify ( 1 ☐ Yes 21		gin? (Specify Yes n, Puerto Rican, et	or No- c.)		American Indian, White, etc. White
21215-0036	vithin 72 ho ne. han "natur a Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0·12)	ucation te completed) College (1-4or 5+)	(Gir	edent's Usual Oc re kind of work do DO NOT use re	one during most	t of working		Kind of Busine	
Maryland 21	be filed ttal Hygi of other event, t	To Be Co	12 years 17. Father's Name (First, Middle, Last) Karl W. Fenske		Secr	etary		er's Name (First, M	fiddle, Maid		Government
Mary	d 2 should th and Men 7 Is marks traumetic		19a. Informant's Name/Relationship (T) Robert D. Grammer	ype, Print) Husban	i i			or or Rural Route I dgemere,			te, Zip Code)
Baltimore, I	Pages 1 and 2 should ent of Health and Men nt: If Item 27 Is merka ry or other traumetic		20a. Method of Disposition  1 □ Burial 2 🛣 Cremation 3 □ 4 □ Donation 5 □ Other (Specify,	Removal from State	b. Place of Dis cemetery, ci	position (Name of ematory or other Cremato	place)	Date	20c.	Location - City	or Town, State
Balti	permit. Pages 1 Department of H Important: If Ite any injury or ot 2002		21. Signature of Funeral Service Licens			22. Name and Ac Connelly	ddress of Facility Funera	al Home ( oint Road	of Dun	dalk, 1	P.A.
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)		ala			cardiac or respira			Approximate Interval Between Onset and Death
8760,	icate be executed physician and sthe burial-transit	Ilcal Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a con  Due to (or as a con  Due to (or as a con							
O. Box 6	death certif e attending od for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ I 4 □ Pregnant at time 9 □ Unknown	etal death	□Ectopic pregn □ Other (specif			_	23d. Date of Month	delivery Day Year
rds, P	sign d be	þ	Part II. Other significant conditions co	ntributing to death but not	resulting in the	underlying cause	e given in Part I.	. 23e.			te to the cause of death?  Probably 4 <b>Ubakno</b> wn
al Records,	The ate ha	Completed						24a.	Was an autopsy performed?	prior deat	
Vita	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 ☐ Inpatient	2 NER/Outpat	ent 3 DOA	Other	of Death (Check		6 □Other (S	Specify)
Division of Vital	ding After fune	atlon: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	The second second second	of 28c.	Injury at Work? 1  Yes 2	28d. Des		jury occurred	
Divis	itel or Attenders after deatlers bisector: led in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, ecify)	street, factory, off	fice		tion (Street or Town, Sta		r Rural Route Number,
	e Hospitel 24 hours a e Funeral l letely filled	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exem	rsicien: To the best of my iner: On the basis of exar and manner stated.	knowledge, de nination and/or	ath occurred at the investigation, in r	ne time, date an my opinion, dea	d place, and due ! th occurred at the	o the cause time, date a	(s) and manne nd place, and	or as stated. due to the cause(s)
)	To the Hospitel (within 24 hours a To the Funeral Completely filled i	Me	29b. Signature and title of certifier	Pull	l M	29c. Lie	cense number	2 (05	29d. E	Date signed (M	fonth, Day, Year)
-	0		39. Name and address of person who o	ompleted cause of death	(Item 23a) (Typ	e, Print)	0×46	DOG	H F	20 N	1021210
· .	Sta Regista		31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	Spark	3 ,1	1	<u></u>		

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

Registrar

31. Date filed (Month, Day, Year) JUN 0 3 2005

umpoul

29b. Signature and title of certifier

Mypritis

111 Penn Street 1000 Da 2. Registrar's Signature

MM

**ORIGINAL** 

29c. License number

OCME

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21201

MAY

30, 2005

			For State Registrar	State of Maryla		epartmei <i>Certifica</i>			id Mental Hy	/giene Reg. No.2	05	18631
Ph	ysicia	an	Decedent's Name (First, Middle,						2. Date of D Month	Day	Year	3. Time of Death
//	Medic	al	ROSIE KATE  4a. Facility Name (If not institution,	GIBSON		4b Cib	Tours	Location of D	MAY	28	1005	255 PM
B)	amin	er	Sinai Hospi-		NONE		111	uo nE	City	40. 000	nty of Death	
	eral			6. Sex 7. Age (In y)		nday) If Under Months	r 1 Year Days	If Under 24 Hours	Hrs. 8. Date of B Min. (Month, D Dec • 5	rth a <i>y</i> , Year) 1928	9. Birthe Cour Teni	place (State or Foreigntry) NESSEE
and	_		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town	or Location						10d. Inside City Limit
Marylan f show	e pai	jo	Maryland Anne		•	Burnie						1 ☐ Yes 2 ☐ N
ith the M or 28a-f	noti	Director	10e. Street and Number				p Code			10g. Citizen	of What Cou	ntry?
th wit	ust be	ai D	204 Cedar Drive			2	1060			U.S.A	٨.	11
d 21215-0036 filed within 72 hours after death with the Maryland Hygier than "natural", or Items 23a or 28a-f show	<b>E</b>	by Funerai	11. Marital Status  1 Never Married 2 X X arrie 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 [X] Mo If Yes, Give Year or Dates:	U.S.	13. Was Dece If Yes, sp 1 Yes	cify Cuba	spanic Origin n, Mexican, P Specify:	? (Specify Yes or N uerto Rican, etc.)	В	lace - Americ Black, White, Cify: Whit	etc.
21215-0036 Id within 72 hours aff giene.	Andical E	Completed	15. Decedent' (Specify only highes	t grade completed)	16a. I	Decedent's Usi (Give kind of w life. DO NOT i	al Occupa ork done d use retired	ation during most of	working	16b. Kind of	Business/In	dustry
a filed withing the other than	the N	mo	Elementary/Secondary (0-12) Grade 8	College (1-4or 5+)		Homemak				Own	Home	
0	tic event,	e	17. Father's Name (First, Middle, L Claude Vaughn	ast)					Name (First, Middle e Spears	e, Maiden Sum	ame)	
Taryiar 2 should be and Menta is marked	other traumatic		19a. Informant's Name/Relationsh						or Rural Route Numi			
	her tr		Clarence Gibson			and the state of the state of	_		en Burnie			21060
Baitimore, permit. Pages 1 ar Department of Heal	injury or of		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp	pecify) Me		Disposition (Na r, crematory or ridge M	iem P	k. 6,	Date /1/2005		•	ryland
Bail permit Depart	any in		21. Signature of Funeral Service L	icensee /M00160		Donald 313 Ta	nd Addres SON 1bot	Fűfera L Aven	l Home, P ue Laure	.A. l, Mary	1and	20707
			a. Part1. Enter the disease, or a shock, or heart failure. List of	complications that caused the de	ath. Do n	ot enter the mo	de of dyin	g, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between
Physic		4	Immediate Cause (Final disease or condition	SEPSIS								Onset and Death
/Med Exam			resulting in death)	Due to (or as a cons	. 1	f):						15 days
		e.	Sequentially list conditions, if any, leading to immediate	b. PNEU MO	, ,	f):				<del></del>		170173
petu:	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Status	=	PILEC	Tic	2US				25 days
68760, filicate be executed a physician and	s the burial-transit	edical Exa	resulting in death) Last	Due to (or as a cons			مم أند	L Aco	-i DENT	-		25 days
Box (eath certif	for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death	3 ☐ Ectopic p 5 ☐ Other (s		J			Date of delive	ery Day Y <i>e</i> ar
rds, P. quires that	should be detached	þ	Part II. Other significant condition	ns contributing to death but not r	esulting in	the underlying	1.1	en in Part I.		tobacco use co		he cause of death? pably 4 Unknow
Division of Vital Records, or Attending Physician: The law requires that death.  Director: After this certificate has been signe	9 5	Completed							24a. Wa auto peri 1 🗆 Yes	s an 24l ppsy ormed?	D. Were auto prior to co- death? 1 \( \text{Yes}	psy findings available mpletion of cause of
Vital Fillian: The certificate	ector,	Be	25. Was case referred to medical examiner?	Hospital:			Cth		Death (Check only			
Of Phys	ral dir	2	1 Yes 2 No  27. Mangrer of Death	1 LM Inpatient 2	ER/Out			4   Nursi	ng Home 5 Res	how injury occ		y)
Sion Itending Jeath. Tor: After	the fune	Certification:	1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n	ation of be		jury M		(? Yes 2 □ No				
Divi	lled in by		4 Homicide determin	building, etc. (Spe	cify)				City or To	wn, State)		al Route Number,
Division ( To the Hospital or Attending 6 within 24 hours after death.	pletely fi	edical	29a. Certifier 1 Certifying (Check only 2 Medical E	g Physician: To the best of my k examiner: On the basis of exami and manner stated.	nowledge, nation and	death occurred /or investigation	at the tim n, in my op	e, date and p pinion, death o	lace, and due to the occurred at the time	cause(s) and date and plac	manner as s e, and due to	tated. o the cause(s)
To t within	E00	Σ	29b. Signature and title of certifier	M.D.		29	c. License	number - OC	00	29d. Date sign	2.8	2-005
	10		30. Name and address of person v		em 23a) (1		INA	1 +11	M , 520	L OF	BAC	Timor

State Registrar 31. Date filed (Month, Day, Year) JUN 0 3 2005

32. Registrar's Signature

			-	State of Marylai	nd / Depa	artment of	Health a	and Me	ental Hvo	iene	.og.b.c.	
			1 - For State Registrar	, , , , , , , , , , , , , , ,		rtificate of				Reg. No.	nns	10001
			Decedent's Name (First, Middle, Last	st)				1	2. Date of Dea		Year	3. Time of Death
	Physicia /Medic	al	David HI	3884	Gr	anat			May	31	2005	- 0440 M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,		of Death	,	4c. 0	County of Dea	
			The Johns Ho.		tel	Balton If Under 1 Yea	r If Under	City	B. Date of Birth		O. Rie	N/A
	Funeral Director			X M 2□ F 7.4	Yrs.	Months Day			NOV.5	930	9. BI	thplace (State or Foreign Duntry) THUANIA
			Usual Residence of Decedent									
	arylan show	L	10a. State 10b. County		ity, Town or Lo							10d. Inside City Limits
	he Ma	ecto		BEACH	BOCA	RATON				40. 0"	(1111	1 ∑Yes 2 □ No
	with t	٦	10e. Street and Number 500 S.E. 5TH AVI	FNHF #S_401		10f. Zip Code	3343	32		iog. Citiz	en of What Co	USA
	ours after death with the Marylan raf', or Items 23a or 28e-f show Examiner mast be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.	Was Decedent of			ify Yes or No-	. 1	4. Race - Ame	erican Indian,
٥	or Ite		1 Never Married 2 X Married	Armed Forces? 1 AYes 2 □ No Δ F		if Yes, specify Cu 1 ☐ Yes 2 🛣 No			ican, etc.)		Black, Whit	te, etc. WHITE
9500-612	72 hours after death with the Maryland "natural", or Items 23a or 28e-f show dical Examiner must be natified at	d by	3 Widowed 4 Divorced	If Yes, Give AR					1		Specify:	
ر د	hin 72 ho e. an "natu	lete	15. Decedent's Ed (Specify only highest gra	ducation de completed)	(Give	dent's Usual Occ kind of work don DO NOT use retii	e durina mos	t of working	g	16b. Kin	d of Business	/Industry
717	1	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	OWNE					LIVE	RY	
פר	be filed tal Hygid d othar avent, II	BeC	17. Father's Name (First, Middle, Last)						(First, Middle,	Maiden S	Sumame)	
<u>Xaa</u>	5 6 9 G	10	SIGMUND		GRAN	AT	AL	TE				PEARLMAN
Maryland	12 shou h and M 7 la mar traumati		19a. Informant's Name/Relationship (		1	ng Address (Stree				-		
_	1 and Healt am 2 ther		MIRIAM GRANAT / 20a. Method of Disposition		Place of Dispo	S.E. 5Th	Ţ	Da #3			ation - City or	I, FL 33432
n o	9 = 5		1 ABurial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, crei	matory`or other pi HEBREW		06/02			-	STOWN, MD
Baltimore,	부문문문		21. Sign number of uneral Service Lice			2. Name and Add			the second second second			
ñ	Dep Imp any		Mechael	Buse	8	900 REIS	STERST	OWN R	0AD <b>-</b> F	PIKES	SVILLE,	MD 21208
ı			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that paused the dea	th. Do not en	ter the mode of d	ying, such as	cardiac or	respiratory arr	rest,		Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition	a Lerebra	1 edes	na						Onset and Death One menth
	/Medical Examiner		resulting in death)	Due to (or as a conse								THE CONTRACT OF THE CONTRACT O
-		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	metasta	ises						Thue months
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c. melan	2 m 4							five months
o O	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a conse								
8/60	ate be	dicai		d								
×	The law requires that the death certificate to has been signed by the attending phys bage 2 should be detached for use as the	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregr	ancy						ad Date of de	£
ROX	atten atten I for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fet	al death 3	☐Ectopic pregnan ☐ Other (specify)				2	3d. Date of de Month	Day Year
j.	t the d by the ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown								
ລັ	res that the de signed by the a be detached f	by P	Part II. Dther significant conditions of	ontributing to death but not re	sulting in the u	nderlying cause o	given in Part I					the cause of death?
ecords,	w require been sig should b	ted	pulmonary metas	tases from melo	noma				1 🗆 Y	es 2	]No 3□Pi	robably 4 🛣 Unknown
ec C	law ras be	Completed							24a. Was a autop	sy	prior to	utopsy findings available completion of cause of
<u> </u>									perfor 1 ☐ Yes		death?	2 <b>X</b> No
Vital K	rysician: The sister of the control	o Be	25. Was case referred to medical examiner?	Hospital:	7500				(Check only or		T0:: /0	
ō	Physer this eral di	-	1 ☐ Yes 2 🔀 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o				e 5 🗌 Resid 3d. Describe h			city)
0	Attanding P death. ctor: After i y the funera	atlo	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation		Injury		fork? ☐ Yes 2 ☐	No .				
DIVISION	or Attanding Physician: ther death. Director: Atter this certifica in by the funeral director, in	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, st	reet, factory, office	е	28	3f. Location (S City or Tow		Number or R	ural Route Number,
	urs aff urs aff sral Di		M	1				//				
	To the Hospital or Attand within 24 hours after death To tha Funeral Director; completely filled in by the	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	y <b>sician:</b> To the best of my kn niner: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred at the vestigation, in my	time, date an opinion, dea	nd place, an occurred	nd due to the o d at the time, o	ause(s) a date and p	ind manner as place, and due	s stated. e to the cause(s)
	o the	Med	29b. Signature and title of certifier	and manner stated.		29c. Lice	nse number		2	29d. Date	signed (Mont	h, Day, Year)
	- > - 0		R	ian Garibaldi	MD	RS:	5-000			May	31, 20	05
	20		30. Name and address of person who	completed cause of death (Ite	т 23а) (Туре,	Print)			600 N	arth L	مود عماود	ref
	đ		Brian Garibaldi no	Johns Hopkins Ho	spital To	our 110 D	octors L.	onrege	Baltmar	e Mari	planel Z	1287
	Sta Registr		Brian Garibaldi mo 31. Date filed (Month, Day, Year) JUN 0 3	2005 Registrars Sign	JF /	Goade						
					-	•						

Registrar

31. Date filed (Month, Day, Year)

JUN 0 3 2005

DHMH 17 Rev 1/2001

Amm, Kerry

30. Name and address of person who completed \_\_\_\_\_ of death (Item 23a) (Type, Print)

9000 Franklin Square

May 30, 2005

Baltimore, MD 21237

			1 _ State		epartment of Health and Certificate of Death			
			Registrar  1. Decedent's Name (First, Middle, Last)		ertificate of Death	2. Date of Death	Nº2005	3 Time of Death
п	Physici /Medic		EMMA H	ODGE		Month	Day Year	7:20PM
	Examin		4a. Facility Name (If not institution, give stree	A	4b. City, Town, or Location of Dea	A. B. S. L.	4c. County of Deat	h
				7. Age (In yrs. last birthd	(Av) If Under 1 Year   If Under 24 Hrs	, ,	0.5	NIA
	Funeral Director		5. Social Security Number 6. Sex 1□ M		Months Days Hours Min		1000	hplace (State or Foreign untry)
	ਹ		Usual Residence of Decedent			1/1901/	1720 0	THE CHECKE
	show	'n	10a. State 10b. County	10c. City, Town o	r Location	1005 1	1 1	10d. Inside City Limits 1. No 2 □ No
	28a-f	Director	10e. Street and Number	7	10f. Zip Code	TORE C	Citizen of What Co	
	h with		1010 W. BAITIMO	REST. APT. 60	4 212	23	45	A.
	ems a	Funeral	11. Marital Status 12. \	Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, White	
36	s afte	by Fu		I ☐ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify:	1001
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. ad other then "natural", or items 23a or 28a-f show event, Ite Madical Evaniral must be natilised at		15. Decedent's Education	on 16a. De	ecedent's Usual Occupation	166	o. Kind of Business/	Industry
215	within 73 ene. then "n	Completed	(Specify only highest grade con Elementary/Secondary (0-12)	mpleted) (G College (1-4or 5+)	Rive kind of work done during most of worker.  DO NOT use retired)			1010
	filed wi Hygien sther th		8 THGRADE  17. Father's Name (First, Middle, Last)	H	EALTH CARE TR	me (First, Middle, Maid		izers BLG.
Maryland	ould be fi Mental H warked ot watic ever	o Be	TAMES NAME (FIRST, MIDDIE, Last)	NEL	1	The (First, Middle, Mail	-	Rown
ary	s 1 and 2 should be f Health and Menta item 27 Is marked other treumatic ev	<sup>2</sup>	19a. Informant's Name/Relationship (Type,		Mailing Address (Street and Number or F	Rural Route Number, Ci		
	ਰ € ^ ≥ ਰ		MARY BRADY (	DAUGHTER) 90	5 ARGONNE DE	, BALTIH		21218
lore	Pages 1 nent of H. int: If iten		20a. Method of Disposition  1. Surial 2 □ Cremation 3 □ Remo	compton	isposition (Name of crematory or other place)		. Location - City or	76
Baltimore,			* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	KING	MEM PARK 06-			
Ba	permit. Departr Importe any inji		Wether K	1. William	22. Name and Address of Ficility	TON AVE.	XOALTO.	MD. 21217
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can	ons that caused the death. Do not ause on each line.	enter the mode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical	1	Immediate Cause (Final disease or condition resulting in death)	gm				
П	Examiner			Due to (or as a consequence of):	: 0			
	₽ .=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	:			
/	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events c resulting in death) Last	Due to (or as a consequence of):				
8760,	The law requires that the death certificate be executed the fas been signed by the attending physician and age 2 should be detached for use as the burial-transit	dical E						
9	tificate ng phy as the		<u> </u>					
Вох	eath certific attending p	an/N	in the next 12 months?	If yes, out <i>co</i> me of pregnancy 1□Live birth 2□Fetal death	3 Ectopic pregnancy		23d. Date of del	very Day Year
o.	at the dea by the arranched for	Physician/Me	1 Ves 2500	4□Pregn <i>a</i> nt at time of death 9□Unknown	5 Other (specify)			54,
Ω.	s that t ned by e detail	by Ph	Part II. Other significant conditions contrib	uting to death but not resulting in th	ne underlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
rds	w requires that been signed I should be det	ed b	ty puterse	m		1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Unknown
Records,	e law re has be je 2 sho	Completed	Coronary.	Setery Des	Reale	24a. Was an autopsy	prior to d	topsy findings available completion of cause of
al B			Deverticul	osis		performed 1 ☐ Yes 24 ☐		2 🗍 No
Vital		o Be	25. Was case referred to medical examiner?  1 Yes 2 West Properties 1 Hosp	ital: 1 Inpatient 2 ER/Outpa	Other	eath (Check only one) Home 5 Residence	6 □Othor (Spec	n/fel
J Of	ding Phys h. After this funeral di	H .	27. Manner of Death 2	8a. Date of Injury (Month, Day Year)  28b. Tim Inju	ne of 28c. Injury at	28d. Describe how in		ary)
sior	Attendir death. ctor: Af y the fur	catlo	2 Accident investigation		M 1 Yes 2 No			
Division	lor Att after d Direct I in by	Certification:	4 Homicide determined 2	<ol> <li>Place of Injury - At home, farm building, etc. (Specify)</li> </ol>	, street, factory, office	28f. Location (Street City or Town, St		iral Route Number,
	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	edical C	(Check only 2 Medical Examiner:	an: To the best of my knowledge, d On the basis of examination and/o and manner stated.	leath occurred at the time, date and place or investigation, in my opinion, death occurred.	e, and due to the cause curred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	` ~	29c. License number	29d.	Date signed (Monti	n, Day, Year)
)	1		I shullbe	Le Ol MI)	V2614	5 6	12/200	05
_	M		30. Name and address of person who complete UBER	eted cause of death (Item 23a) (Ty	(9 FALLS B	BALT	omD	)
**	Sta Registi		31. Date filed (Month, Day, Year)  JUN 0 3 2005	32. Registrar's Signature	and a			

			State of Maryland / Department of Health and I  State Registrar  State Certificate of Death	Mental Hygi	iene 2005	18634
•	Exam	dical niner al	1. Decedent's Name (First, Middle, Last)  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  10 M 20 F  11 M 20 F  12 M 20 F  13 M 20 F  14b. City, Town, or Location of Death  15 Months Days Hours Min.		Day Yeer 2005  4c. County of Death	3. Time of Death 9. 05/ M  ce (State or Foreign
	laryland 21215-0036  2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  Bis marked other than "naturel", or Items 23a or 28a-f ehow becometic event, the Medical Examinat must be a milligual at	Director	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  CAMARO  10e. Street and Number  10f. Zip Code  31206		Dg. Citizen of What Countr	
	5 <b>2</b> 2	Completed by Funeral	Armed Forces?  1 Never Married 2 Married 1 Yes, Specify Cuban, Mexican, Puert 1 Yes, Specify Cuban, Mexican, Puert 1 Yes, Specify:  1 Specify Only highest grade completed)  Elementary/Secondary (0-12)  Armed Forces?  If Yes, specify Cuban, Mexican, Puert 1 Yes, Specify:  1 Yes, Specify Cuban, Mexican, Puert 1 Yes, Specify:  1 Yes, Specify Cuban, Mexican, Puert 1 Yes, Specify:  1 Yes, Specify Cuban, Mexican, Puert 1 Yes, Specify:  1 Yes, Specify Cuban, Mexican, Puert 1 Yes, Specify:  1 Yes, Specify Cuban, Mexican, Puert 1 Yes, Specify:  1 Yes, Specify Cuban, Mexican, Puert 1 Yes, Specify:  1 Yes, Specify Cuban, Mexican, Puert 1 Yes, Specify:  1 Yes, Specify Cuban, Mexican, Puert 1 Yes, Specify:  1 ON OF Use Specify:  1 ON OF Use Puert 1 Yes, Specify:  1 ON	1	Black, White, et	c.
	Maryland 21215-0036 to 2 should be filed within 72 hours aft to 27 is marked other than "naturel", or renumetic event, the Medical Exercite	To Be Cor	JAMSS KALINOWSKI AOSS  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru	me (First, Middle, N		
	Baltimore, I permit. Pages 1 and Department of Healt Importent: If item 2' any injury or other:	once.	20a. Method of Disposition  Disposition (Name of cametery, crematory or other place)  Donation 5 Other (Specify)  21. Signal re-of Funetal Service Licensee  20b. Place of Disposition (Name of cametery, crematory or other place)  Cametery, crematory or other place)  Cametery, crematory or other place)  22. Name and Address of Facility	· 4.	20c. Location - City or Tow	7, State
:05PM	Examine	al er	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	correspiratory arre	1	Approximate nterval Between Onset and Death
05009	ox 68760, certificate be executed adding physician and use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.			
1-1-9	S, P.O. Box 68' es that the death certificat igned by the attending phy be detached for use as th	Completed by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month D	/ Day Year
16	- A D	eted by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Ling disease,  Devipheral VASCULAN disease	1 X Ye		bly 4 🗆 Unknown
iydoo		e Compl		24a. Was ar autops; perform 1 Yes 2	y prior to complete death?	sy findings available pletion of cause of
(V)	Of Phys ral di	atlon: To B	examiner?  1  Yes  No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing F  27. Manner of eath		once 6 Other (Specify)	Hospice
EPNER	Division  Hospitel or Attending 124 hours after death.  Funeral Director: After delety filled in by the fune	al Certification:	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.)	City or Town	ause(s) and manner as stat	ted.
1	To the H within 24 To the Fi	Medical	one) and manner stated.	· · · · · · · · · · · · · · · · · · ·		
	6	State	29b. Signature and title of certifier  29c. License number	Balto. n	nd 21209	~
		istrar	JUN 0 9 LOOS			

			For State Registrar		State o	f Marylai	nd / Depa	artmen rtificate			ind M		Reg. N	201	)5	18635
	Physici /Medio Examin	al	Decedent's Name (First, Mid Franklin     A. Facility Name (If not institute			mber)			Town, or	Location o	f Death	2. Date of Do Month June	1,	2005 c. County of I		3. Time of Death 6:00 A
	Funeral Director		1834 Dunmere F 5. Social Security Number 215-03-6479	6. Sex	M 2□F	7. Age (In yrs	. last birthday) 88 Yrs.	If Under Months	inda] 1 Year Days	lf Under	24 Hrs. Min.	8. Date of Bi (Month, D July 2	rth ay, Yea 21,1	Balt 916		lace (State or Foreign try)
	e Maryland 8a-f show difficult	ctor		imore	)	10c. C	ity, Town or Lo	.k								0d. Inside City Limits 1 ☐ Yes 2 🌠 No
	death with the ms 23e or 21	Funeral Director	10e. Street and Number  1834 Dunmere I  11. Marital Status		2. Was Dec	edent Ever in t	U.S. 13.		21222		gin? (Spe	ocify Yes or N Rican, etc.)		USA  14. Race -	Americ	an Indian,
-0036	72 hours after death with the Maryland natural; or Itams 23e or 28e-f show deal Evantreet mast be modified at	by	1 Never Married 2 M M 3 Widowed 4 Divorce	ed	Armed For 1 X Yes If Yes, Gir Year or D	2 □ No ve	16a. Dece	1 □ Yes :	No No	Specify:				Specify:  Kind of Busin		te
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Maryland	s 1 and 2 should be ( Health and Mental is itam 27 is marked or other traumatic ave	To Be	Henry Heim  19a. Informant's Name/Relatio		e, Print)			•	•	A) and Numbe	nna I	Hick	per, City	or Town, Sta	ate, Zip	Code)
Baltimore, N			Dellamae Heim  20a. Method of Disposition  1X Burial 2 Cremation  4 Donation 5 Other		moval from	State	Place of Dispo cemetery, crei	sition (Nan	ne of ther plac	е)	C	dalk,Mo <sub>ate</sub> 4,2005	20c.	Location - Cit	•	wn, State
Balti	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service 23a. Part I Enter the disease,	Q\$	2	caused the des						ome Of Road,		dalk, dalk,	A. MD.	21222 Approximate
68760,	death certificate be executed  Medical Examiner  ad for use as the burial-transit	Ical Examiner	shoot, or heart failure. L Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. b. c.	Due to	Tung	equence of):	in .								Interval Between Onset and Death  Yew
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Records, P.	The law requires that the tto by the bas been signed by th bage 2 should be detache	by	Part II. Dther significant cond	tions cont	ributing to d	eath but not re	esulting in the u	nderlying c	ause give	en in Part I.		1 🗆	Yes	\rangle .	ute to th	e cause of death? ably 4 □Unknown
Vital Rec		e Completed	25. Was case referred to medi	cal					5-04	26. Place	of Death	24a. Wa auto per 1 Yes	ormed?	prio dea	r to cor th?	psy findings available inpletion of cause of
of	ing Phys	atlon: To B	examiner? 1 Yes 22 No  27. Manner of Death 1 Natural 5 Pen 2 Accident	ding stigation		Inpatient 2[ of Injury oth, Day Year)	ER/Outpatien 28b. Time o Injury		8c. Injun Worl	er: 4□ Nu	rsing Ho	V	idence	6 Other (ury occurred	(Specify	')
Division	after Dira	I Certification:	4   Homicide	mined	build	ling, etc. (Spec	home, farm, st cify) nowledge, deat			no date an		City or To	òwп, Sta	ite)		I Route Number,
	To the Hospital within 24 hours a To the Funaral I	Medical		al Examin	er: On the b		nation and/or in	vestigation 290	, in my o	pinion, dea	th occurr	ed at the time	, date a	nd place, and Date signed (A	due to	the cause(s)
_	8		30. Name and address of pers	Then	M.O.	-301	om 23a) (Type,	Print)	PI	ay	Ba	alto, M	0 2	1202		
•	Sta Regist		31. Date filed (Month, Day, Ye JUN 0	3 200	5 32.	egistrar's Sign	nature (g)									

Mildred Hutto

		T = For State Registrar  1. Decedent's Name (First, Middle, La	eth	Cei	rtificate of	Death	2. Date of De	Reg. No.	2/Time of Dooth				
Physi		Mildred Elizabe					Month Mav	25 200	ear 3 Time of Death 5 7:45 PM				
/Med Exam		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Deat		4c. County of					
		Genesis Health				aston			lbot				
Funera Directo			Sex 7. Age (In yrs. 1 ☐ M 2 ☐ F 73	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		th y, Year) 1931	). Birthplace (State or Foreigr Country) New York				
yland yland		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits				
a-fsh	ctor	MD Talbot		Roya1	0ak				1 ☐ Yes 2√∑ No				
death with the Maryland oms 23a or 28a-f show if further notified at	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?				
s 23a	rai	6785 Edge Road	12. Was Decedent Ever in U	C 12		1662	Docity Voc as No	USA	American Indian,				
be filed within 72 hours after death with the Marylar Ital Hygiene. d other than "neturel", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 XDivorced	Armed Forces?  1  Yes 2  No If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2🎇 No	an, Mexican, Puerl	to Rican, etc.)	Black, Specify:	white				
72 hou	ted	15. Decedent's E (Specify only highest gr.	ducation	16a. Dece	dent's Usual Occup kind of work done	pation	dkina	16b. Kind of Busi	ness/Industry				
ithin 7. ne. hen 1.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)	ining .						
e filed wat Hygier other the		12 17. Father's Name (First, Middle, Last	0	sec	retary	18. Mother's Nar	me /First. Middle.	aircr Maiden Sumame)					
2 should be 1 and Mentat I Is marked or eumatic eve	To Be	Joseph Amber Gor	man	( and 14 15		Mab1e	Maller	У					
s 1 and 2 should f Health and Men item 27 Is marke other treumatic		19a. Informant's Name/Relationship ( Chery1 Heckard/			.O. Box			er, City or Town, St D 21662	are, Zip Codej				
	H	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☒ Donation 5 ☐ Other (Speci	Removal from State	Place of Dispo	osition (Name of matory or other place		Date	20c. Location - Ci	ty or Town, State				
permit. Page Department of Importent: If any injury or	olice.	21. Signature of European Service Lice	//	/				Baltimon	re Street				
Physicia		Baltimore, MD 21201  23a. Pht.1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirty, or heart failure. List only one cause on a chiline.  Immediate use (Final disease or condition)  Approximate Interval Between Consett and Death Cons											
/Medica	1	a. Due to (or as a consequence of):  Sequentially list conditions.  b. Alkows lines is amendial.  years											
Examine		Sequentially list conditions,	b. Atheroselle	nosis,	querdiz	2h			years				
ted nsit	Examine	Figure 1 and the control of the cont											
execu n and ial-tra	Exar	that initiated events resulting in death) Last	C. Due to (or as a conseq	uence of):									
rificate be executed ng physician and as the burial-transit	edical		d										
death certiff e attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnation of Live birth 2 ☐ Feta 4 ☐ Pregnant at time of degical Unknown	I death 3	Ectopic pregnancy Other (specify)	у		23d. Date of Month					
requires that the leen signed by th hould be detache	y Ph	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use contrib	ute to the cause of death?				
quires n sign uld be	ed by						101	res 2□No 3	☐ Probably 4 Unknown				
s S	Completed						24a. Was	an 24b. We	re autopsy findings available				
The ate h page	Com								or to completion of cause of ath? ]Yes _2□ No				
ysicien: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?	II.			/	ath (Check only o	one)					
nys I di	5 5	1 Tes 2 No	Hospital: 1 Inpatient 2 I	ER/Outpatier 28b. Time o	-77	4 Nursing F		dence 6 Other					
ding h. After funer	tlon	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wor	rk? Yes 2 ☐ No	200. Describe	low injury occurred					
of attending Physical death.  Director: After this in by the funeral director.	ertification:	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	90 00 00 00	ome, farm, str y)			28f. Location (\$ City or Tox	Street and Number vn, State)	or Rural Route Number,				
To the Hospitel or Attending P. within 24 hours after death. To the Funerel Director: After the completely filled in by the funera	ledical C	29a. Certifier (Check only one)  Certifying Plants one)  Certifying Plants one)	nysicien: To the best of my kno miner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the tir vestigation, in my o	me, date and place opinion, death occu	e, and due to the arred at the time,	cause(s) and mann date and place, and	er as stated. I due to the cause(s)				
To the To the Comp	Σ	29b. Signature and title of certifier	m Vin		29c. Licens	se number		29d. Date signed (	Month, Day, Year)				
		146	Al mo		176	5955		5.2	1.00				
	ļ	30. Name and address of person who	completed cause of death (Item	23a) (Type,	DUTCHM	ana la	NIZ F	ASTON I	ND 21601				
9	itate	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature 🎤	JUJ CVIII	וא ביודיו	11Vhm for	212100 1	I DIVOI				
Regis		IUN 0.3 20	15 Keleva L	S. Sales	Mary Control								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

amend Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last)
Lucille 2. Date of Death 3. Time of Death Laverne Irving **Physician** 31 2005 11:30a /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 345 Wellham Avenue Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 ☐ M 2 🖸 F Yrs. Director 225-54-1063 68 4-16-37 Va Usual Residence of Decedent Maryland 10b. County 10c. City. Town or Location 10d Inside City Limits 10a State 28e-f show traumatic event, the Madical Examiner must be notified at 1X Yes 2 No Director Red Oak Charlotte the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9510 Barnsville Rd with 5 238 P.O. Box 23964 USA 2 should be filed within 72 hours after death in and Mental Hygiene. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th I. B. M. yrs. Administration Varies 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kermit Wilson Lucille Blackwell ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48640 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health ar Health itam 27 i Otis Wilson Brother 6015 Sturgean Creek Parkway, Midland, Michigan other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ö Department of Important: If any injury or one St. Level Bapt. Ch. 6-5-05 ' 4 ☐ Donation 5 ☐ Other (Specify) Clarksville, Va. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Md. 21202 Lad wans March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** trterioseleration /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attanding Physician: The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Box 68760 Physiclan/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ ed bluods 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 Tes 1 Yes 2 🗆 No 21 No 25. Was case referred to medical examiner?
1 X Yes 2 ☐ No Be 26. Place of Death (Check only one) Family Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Friend Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ۵ this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 🗆 No Director: in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide filled Hospital within 24 hours a To tha Funsral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DROKT D000 use of death (Ifem 23a) (Type, Print) 25 Registrar's Signal 31. Date filed (Mon 2005 State

DHMH 17 Rev 1/2001

Registrar

			_ FOI	rtment of Health and Menta ificate of Death	I Hygier	2000	18638					
			Decedent's Name (First, Middle, Last)		e of Death	W 30 V	3. Time of Death					
	Physici /Medic		Louis Frederick Jones,	Sr. Ju		Pay Year 2005	10:50 PM					
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death						
			1718 Middleborough Rd.	Essex		Baltimo						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Yrs. 7. 1 7. 4 7. Age (In yrs. last birthday) 7. Yrs.	Months Days Hours Min. (Mo	e of Birth nth, Day, Yea		place (State or Foreign ntry)					
	Director		220 22 1656	July	7 19,19	928   Mar	yland					
	yland how		10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits					
	Ba-fs	ctor	Maryland Baltimore Esse:	X			1 ☐ Yes 2 🔯 No					
	or 28	Director	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Cou	ntry?					
	be filed within 72 hours after death with the Maryland tal Hygiene d other than "natural", or items 23a or 28a-f show event, the Medical Estatinar must be notified at	era	1718 Middleborough Rd.  11. Marital Status 12. Was Decedent Ever in U.S. 13. W	21221	s or No-	USA 14. Race - Ameri	can Indian					
_	fter d	Funeral	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No	as Decedent of Hispanic Origin? (Specify Ye Yes, specify Cuban, Mexican, Puerto Rican, e	etc.)	Black, White,	etc.					
3	72 hours after natural, or ite	by	3 ☐ Widowed 4 ☐ Divorced If Year or Dates: WW II 1	Yes 2 No Specify:		Specify: Wh:	ıte					
3-003p	72 hc	Completed	(Specify only highest grade completed) (Give k	ent's Usual Occupation ind of work done during most of working	16b.	Kind of Business/In	ndustry					
7	within ene. than "	Idm	Elementary/Secondary (0-12) College (1-4or 5+)	o NOT use retired) r Plumber	,	Olimbina						
N 0	filled v Hygie ther t	မ Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (First,		Plumbing en Sumame)						
and	ld be ental ked o	To Be	John Louis Jones	Barbara He	enriett	a Siedlei	c					
3	permit. Pages 1 and 2 should be Department of Health and Menta Important; if item 27 is marked any injury or other traumatic a DDGs.	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or Rural Route	Number, City	y or Town, State, Zij	o Code)					
Ma.	and 2 laith a la 27 la		Lillian Jones (Wife) 1718	Middleborough Rd. Ba	altimor	e, Md. 2	1221					
o Ce	of He		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State	atory or other place)		Location - City or To						
Ĕ	Pag ment lant; l		'4 □Donation 5 □Other (Specify) Oak Lawn			ltimore,	Maryland					
Банттоге	Separit Depart D		21. Signature of Funeral Service Licensee 22.	Name and Address of Facility ruzdzinski Funeral Ho	me P.A	۸.						
	40364	1	23a. Part1 Enter the disk ise, or complications that caused the death. Do not enter	40/OLd Eastern Avenu	ie Esse	x, Md. 21	Approximate					
		_	shock, and art failure. List only one cause on each line.				Interval Between Onset and Death					
	Physician /Medical		Immedia Cause (Final disease) r condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
	Examiner		Satis to the sate of source and	un sotus Dis	ease							
		ner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury									
V	acuted ind transi	Examine	that initiated events c.	0								
Š,	cate be executed physicien and the burial-transit		resulting in death) Last Due to (or as a consequence of):									
09/89	physics the b	dlcal	d									
BOX	leath certificate attending phys I for use as the	hysician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliv	ery					
ň	death e atten ed for u	Icla	in the past 12 months?  1 Vac 2 No.	Ectopic pregnancy Other (specify)		Month	Day Year					
5	that the deled by the a	hys	9 Unknown	_								
'n	Se Ded	by P	Part II. Other significant conditions contributing to death but not resulting in the unc			o use contribute to t						
coras,	w requir been sh should	ted	Chronic obstructive pul	money e	1 ☐ Yes	2 No 3 Prot	bably 4 Honknown					
ه	law asb 2 sl	ompleted	glodder concer.	248	a. Was an autopsy performed?	prior to co	opsy findings available — impletion of cause of					
Vital H	Icien; The certificate hi ector, page	O			Yes 2 🔀		2 No					
7		o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death (Check 3 DOA Other: 4 Nursing Home 5		6 □Other (Specie	6.1					
ō	ding Phys h. After this funeral di	H- 1	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at 28d. De	scribe how in		ry)					
DIVISION	Attending For death.  Sctor: After by the funer.	atloi	1 XNatural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No								
N N	el or Attendin s after death. I Director: Af d in by the fur	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  Getermined  28e. Place of Injury - At home, farm, street building, etc. (Specify)		ation (Street	and Number or Rura	al Route Number,					
2	itel or irs aft rel Dli led in					· 						
	To the Hospitel or Attendil within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	29a. Certifier  (Check only   Check only	estigation in my opinion, death occurred at the	e time date a	nd place, and due to	o the cause(s)					
	thin 2 the othe	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d. [	Date signed (Month,	Day, Year)					
	F 3 F 8		Conged atarases up	D-28097		6/210	<u></u>					
	AH		30. Name and address of person who completed cause of death (Item 23a) (Type. P	rint) O1		-1-10-						
	101		29b. Signature and title of certifier  Nonald Outarasio MO  30. Name and address of person who completed cause of death (Item 23a) (Type, P  RONAL AT TWTS/D 1576  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Merrett Blld. Su	tit!	y Balt.	, Md. 21222					
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Carolla .		,						
	Registi	rar	JUN 0 3 2005 Flore St A									

amend item#195, perrin, 1874, 6/3705 II State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month UNE Day **Physician** 2005 3:55P RROLL ANDOLPH /Medical 4b. City, Town, or Location of Death 4c. County of Death Balt imore 4a. Facility Name (If not institution, give street and number) **Examiner** Saint Joseph Medical 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 □ F Days Hours Min. 226-32-0670 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits item 27 is marked other then "neturel", or items 23a or 28e-1 show other treumetic event, it is Madical Examinal from the notified at 1 Yes 2 No Directo MARYLAND NOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify: BLACK Specify: If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4BORER GRADE Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental NEL ENNIE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City o. permit. Pages 1 and 2 Department of Health at Importent; If item 27 Is eny injury or other treu once. SISTER RAEDWARDS JOPPA 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Zurial 2 ☐ Cremation 3 ☐ Removal from State RBUTUS CEMETERY.06-07-05 ARBUTUS MARYLAND • 4 □ Donation
• 5 Other (Specify) 22. Name and Address of applity BROWN TR. FUNERAL 2740 N. FULTON AVE., BALTO, MD. 21. Signajore of Furieral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASPIRATION PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ. 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No 24a. Was an certificate has autopsy 2.X No Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Cther: 1 🗌 Yes No. Inpatient 2 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Mapher of Leath 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred Director: After 5 Pending investigation 1 Natural 2 🗌 No 1 Tes 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE TOWSON, MARYLAND 21204 7601 OSLER FRANCIS KHOO. M.D . Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) 2005

,,,				State of Maryland	1/Dens	artment o	f Health a	nd Ments	al Hyniene	_	
		-	For State Registrar	State of Maryland			of Death	nd Mente	Reg. No.	2005	18610
			Decedent's Name (First, Middle, Last)						te of Death	Year	3. Time of Death
	Physicia /Medic		Ruby P. Jacobs						y 28, 20	005	11:08 p <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give st			4b. City, Tow	n, or Location of	Death		County of Death	
			University of Mary 5. Social Security Number 6. Sex	land Hospital	ast birthday)	Balti If Under 19	more Cit	4-Hrs. 8. Da	te of Birth		place (State or Foreign
	Funeral Director			M 2⊠F 57	Yrs.	Months Da	ays Hours	Min. 1 (M	onth, Day, Year)	947 Virg	inia
	ק		Usual Residence of Decedent	10c City	, Town or Lo	cation					10d. Inside City Limits
	haryla s show	ō				Oution					1∭Yes ¿□No
	28a-	rect	MD Anne Aruno  10e. Street and Number	iei rasa	adena	10f. Zip Co	de		10g. Citiz	zen of What Cou	ntry?
	th with	Funeral Director	8025 Woodholme Circ	1e		21122	)		Unite	ed STate	S
	tems	uner	11. Wantar States	<ol><li>Was Decedent Ever in U.S Armed Forces?</li></ol>	S. 13.	Was Decedent If Yes, specify	of Hispanic Origi Cuban, Mexican,	in? (Specify Yo Puerto Rican,	es or No-	<ol> <li>Race - Amen Black, White,</li> </ol>	can Indian,
36	d within 72 hours after death with the Maryland jiene. I them netural; or Items 23a or 28a-f show The Madical Examerer must be ricilized at	by Fi	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:		1 □ Yes 2🌠	No Specify:			Specify:Whit	e
9-0	2 hou letura ical E	ted	15. Decedent's Educ			dent's Usual O	ccupation one during most	of working	16b. Kir	nd of Business/In	dustry
218		Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use n	etired)	or morning			
121	a filed within al Hygiene. other than '		12 17. Father's Name (First, Middle, Last)		Barm	aid	18. Mother	's Name (First	Hart , Middle, Maiden	or Way Sumame)	Inn
and	0 50	To Be	James Davis					Ruth Ta			
Maryland 21215-0036	de E	-	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailin	ng Address (Si			e Number, City or	Town, State, Zij	o Code)
			Charles Jacobs / H			Midwoo	-	Baltin Date	nore, MD		- Charles
Baltimore,			20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ Re	emoval from State	emetery, cre	sition (Name of matory or other	r place)			cation - City or T	
Him	t. Pa ntmer ntant njury		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature  Funeral Service/bicense		23	Name and A	ddress of Facility	,	2005 Bal		MD
Ba	permi Depa Impo any i		I we do	ug (		Kirkley	-Ruddic	k Funeı	cal Home Glen Bui	P.A.	21061
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	e cause on each line.	. Do not en	ter the mode o	dying, such as o	ardiac or resp	iratory arrest,		Approximate Interval Between
	Physician	ë s	Immediate Cause (Final disease or condition	Hypertensi	ve at	herosch	erotic ca	vdiova	swlar d	lisease	Onset and Death
	/Medical Examiner		resulting in death)	Due lo (or as a consequ	ience of):						
	118434	e.	Sequentially list conditions, if any, reading to min educible cause. Enter Underlying Cause, (Disease or injury	Dua to (or as a consequ	ence d):						
	cuted ad ransit	Examine	that initiated events								
90,	cate be exacute physiclen and the burial-trans		resulting in death) Last	Due to (or as a consequ	ience of):						
8760,	The law requires that the death certificate be exacuted to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	d								336 331
Box 6	eath certific attending p for use as f	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna 1□Live birth 2□Fetal		⊒Ectopic pregr	1000		2	23d. Date of deliv	,
	death	sicta	in the past 12 months? 1 ☐ Yes 2 XNo	4 Pregnant at time of de		Other (speci				Month	Day Year
P.0	nat the de d by the letached	Phy	9 ☐ Unknown  Part II. Other significant conditions con	stributing to death but not resu	ulting in the t	inderlying caus	e given in Part I.	2	3e. Did tobacco u	se contribute to	the cause of death?
ds,	signed I	d by		rellirus, cu			he live		1 ☐ Yes 2 [	□No 3Æ Pro	bably 4 Unknown
Records,	w require been si should l	lete						2	4a. Was an	24b. Were aut	opsy findings available ompletion of cause of
Re	The lav	Completed							autopsy performed?	death?	
Vital		Be C	25. Was case referred to medical examiner?				26. Place	of Death (Che	ck only one)		
of V	Q. 5. 9	2	1. Yes 2 No		ER/Outpatie				Residence (		fy)
ou c	ding Ph h, After th funeral	lon:	27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 280.	Injury at Work? 1 ☐ Yes 2 ☐ N		rescribe now injur	y occurred	
Division	deat deat ctor: / the	flca	3 Suicide 6 Could not be	28e. Place of Injury - At ho	me, farm, st	reet, factory, o	ffice	28f. Lc	ocation (Street and ity or Town, State	d Number or Rui	al Route Number,
Div	s after or all Dire	Certification:	4 Homicide	building, etc. (Specify							
	To the Hospitel or Attent within 24 hours after dealt To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Examin	sician: To the best of my kno ner: On the basis of examina	wledge, dea tion and/or ir	th occurred at investigation, in	he time, date and my opinion, deat	d place, and du th occurred at t	ue to the cause(s) the time, date and	and manner as place, and due	stated. to the cause(s)
	o the ithin 2 o the omple!	Med	one)  29b. Signature and title of certifier	and manner stated.		29c. L	icense number		29d. Dat	e signed (Month	, Day, Year)
	F 3 F 8		1 Jasha 21	Loen ne	D		OCME		Ma	ay 29, 2	005
1	3 0		30. Name and address of person who co	4	23a) (Type	, Print)	D Ct	not D	-1+-1	M1	and 21.201
-	,			22. Redistratis Signa	,D <sub>1</sub>	111	renn Str	eet B	altimore	, maryıa	and 21201
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	005	J.	gover)					

		1 - State Registrar	State of Marylan		rtment of H		•	giene Reg. No. 2 0 0		
Physic	Decedent's Name (First, Middle, Last)  Physician						2. Date of Dea Month	ath Day Yea	1.4	
/Med Exam	ical	Genevieve Jacob	4b. City, Town, or	_	May 20	4c. County of De				
Funera Directo		141-20-8663	M 2反F 7. Age (In yrs. 93	last birthday) Yrs.	Rockvil If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Birt Min. (Month, Day Apr 29,	v. Year) (	mery irthplace (State or Foreign country) Jersey	
Iryland 21215-UU36 should be filed within 72 hours after death with the Maryland to Mental Hygiene. marked othar than "natural; or Itams 23a or 28a-1 show matic event, Ita Medical Everginar must be notified at	d by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Y  11 Road  2. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	.S. 13. \	ville   10f. Zip Code   20855		? (Specify Yes or No- uerto Rican, etc.)	10g. Citizen of What 0  USA  14. Race - An Black, Wt Specify: W	nencan Indian, nite, etc.	
Maryland 21215-0035 d 2 should be filed within 72 hours af th and Mental Hygiene. 77 is markad othar than "natural; or traumatic evant, Ita Medical Evant	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  12  (Giv life.			kind of work done during most of working DO NOT use retired) teacher			educati	education	
ryland hould be fil d Mental H markad oth matic evan	a	17. Father's Name (First, Middle, Last)  Ruben Jaffe  19a. Informant's Name/Relationship (Type, Print)  19b. Mail			a Address (Street	18. Mother's Name (First, Middle, Maiden Surname)  Ida Herschler  (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
Baltimore, Marylan permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked, any injury or other traumatic evonce.		Ellen Jacobs/daught  20a. Method of Disposition  1 Burial 2 Cremation 3 Re  4 Donation 5 Other (Specify)	ter 20b. F	2985		Lane E	11icott Ci		1042	
Balti permit. Departr importa any inju		21. Si nature o Euneral Service License	11/100	В	altimore,	, MĎ 2	1201	. Baltimor	e Street	
cate be axecuted cate by axecuted cate by axecuted cate by bysician and cate by axecuted cate by axecuted cate by axecuted cate by axecuted categories.		23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Underlying cause (Underlying cause (Underlying cause (Underlying cause (Underlying cause (Underlying cause)))  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							Approximate Interval Between Onset and Death	
P.O. BOX 68 that the death certifica ad by the attanding ph detached for use as th	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregna 1  Live birth 2 Feta 4 Pregnant at time of d	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year	
Records, P. The law requires that tee has been signad by	b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part				en in Part I.	23e. Did to	. /	to the cause of death?  Probably 4 □Unknown	
- ig LT	Completed	OF Manager of the day of the second of the s					1 ☐ Yes	prior to rmed? death? 2 No 1 Ye	autopsy findings available completion of cause of es 2 No	
SION OF tanding Physicath.  tor: After this the funeral di	Certification; To Be	25. Was case referred to medical examiner?  1   Yes								
DIVI To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
To tha within 2 To the Complete	Medical	29b. Signature and title of pertifier  29c. License number  29d. Date signed (Month, Day, Year)								
		30. Name and address of person who con Charles Mills	hael Har	riso	Print) Co	lum	hia n	nd. 210	44	
S Regis	tate trar	31. Date filed (Month, Day, Year) JUN 0 3 2005	32. Registrar's Signa	ature	K		1		,	

			State of Maryland / Department of State of Maryland / Department of Certificate of			ene . No. 2 11 11 5	10010			
			1. Decedent's Name (First, Middle, Last)		. Date of Death		3. Time of Death			
	Physici		Morris Johnson	M	Month Iav 2	7 2005	1340 M			
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town,	or Location of Death		4c. County of Death				
			Genesis Elder Care @ Spa Creek   Annapo			Anne Arur				
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 72 Yrs.	r If Under 24 Hrs. 8 s Hours Min. M	I. Date of Birth (Month, Day, Y Ia. y 19	9. Births 1933 Mary	place (State or Foreign htry) 1.and			
	P ,		Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or Location			,	Od. Inside City Limits			
	shov	ក				1	1 ☐ Yes 2 ☐ No			
36	the N	Director	Maryland Baltimore North East  10e. Street and Number 10f. Zip Code		100	. Citizen of What Cour	ntry?			
	with 3a or		114 North Main St. 219	901	-	USA	N .			
	death ms 2;	Funeral		Hispanic Origin? (Speci ban, Mexican, Puerto Ri	fy Yes or No-	14. Race - Americ				
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mantal Hygiene. If item 27 is marked other then "naturel", or Items 23e or 28e-f show or other treumatic event, the Medical Example must be notified at	Completed by Fu	Armed Forces? If Yes, specify Cul  1 Never Married 2 Married 2 Married 1 Never Married 2 Married 2 Married 2 Married 1 Never Married 2 M		can, etc.)	Black, White,				
21215-0036	2 hou		15. Decedent's Education 16a. Decedent's Usual Occu (Specify only highest grade completed) (Give kind of work done	upation e during most of working	16	6b. Kind of Business/In	dustry			
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and	ba fil ntal H od oth even	Be	17. Father's Name (First, Middle, Last) Otho Johnson Sr.	18. Mother's Name (I		uden Sumame)				
2	should ind Man marke umatic	To	19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Stree</i>			City or Town State Zin	Code)			
<u>⊠</u>	and 2 s ealth an m 27 is i		Otho Johnson (Brother) 106 Holecla			s, Md. 2				
re,	s 1 ar f Hea item other		20a. Method of Disposition 20b. Place of Disposition (Name of	Dat	te 20	c. Location - City or To	own, State			
E	Page nent o nt: # iry or		1 \( \text{Burial} 2 \) Cremation 3 \( \text{Removal from State} \) 1 \( \text{Donation} \) 1 \( \text{Donation} \) 2 \( \text{Cemetery} \) 1 \( \text{Cemetery} \)	6-2-0	)5 Cr	ownsville	e, Md.			
Baltimore, Maryland	permit. Pages 1 and 2 Oepartment of Health a Importent: if item 27 is eny injury or other tre		21. Signature of Funeral Service Licensee Will Name and Add	se of Eacilisons t St. Anna						
			23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dy				Approximate			
ı	Pnysician	dical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition				Interval Between Onset and Death			
	/Medical		disease or condition resulting in death)  Due to (or as a consequence of):							
	Examiner		Sequentially list conditions.							
3	be isit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listest or if its that initiated events c.							
_	xecut and al-tran		that initiated events c. resulting in death) Last Due to (or as a consequence of):							
8760,	rcate be executed physician and s the burial-transit		d							
9	tificati ig phy as the	ledic		-						
Вох	eath certifi attending   I for use as	M/ue	IF FEMALE: 23b. Was decedent pregnant  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery  Month Day Year					
Ю. Ш	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months?  1   Yes 2   No 9   Unknown   9   Unknown   1   1   1   1   1   1   1   1   1							
<u>α</u>	res that the de ignad by the a ba detached to		Part II. Other significant conditions contributing to death but not resulting in the underlying cause g	given in Part I.	23e. Did toba	cco use contribute to the	he cause of death?			
rds	quires n sigr uld ba	d by			Yes	2 □ No 3 □ Prob	pably 4 □Unknown			
Records,	law requir as been si 2 should	Completed			24a. Was an	24b. Were auto	psy findings available			
	The lav	mo			autopsy performe 1 Yes 25	id? death?	mpletion of cause of 2□ No			
Vital		Be C	25. Was case referred to medical 26. Place of Death (Check only one)							
	Physic this ce al dire	To	T Inpatient 2 Envoutpatient 3 DOA			ce 6 □Other (Specif	(y)			
o Li	Attending Physician: r daath. actor: After this certific by the funeral director,	lon:	27. Manner of Death  28a. Date of Injury  (Month, Day Year)  28b. Time of Injury  W. W		ld. Describe how	injury occurred				
isio	death ctor: /	Certification:	3 Suicide 6 Could not be 399 Bloom of Injury. At home form street feetons efficient	M 1 Tyes 2 No			. Location (Street and Number or Rural Route Number,			
Division of	after Dirac d in by		4 Homicide determined building, etc. (Specify)	,	City or Town, State)					
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	ledical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.		the state of the					
	To th withir To th comp	Me	29b. Signature and ittle of certifier 29c. Licer	nse number 6	290	1. Date signed (Month)	Day, Year)			
,	OXI		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	) -	1.0	1				
	18		Goy & Sovere 2108 Di Don h Will	Ch. L. M	1 2/6	19				
	Sta Registi		29b. Signature and hitle of certifier 29c. Licer  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32 Registrar's Signature				,			
	3.0		JUN V D - V TANKS J							

DHMH 17 Rev 1/2001

UNK Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-03613 NJM State of Maryland / Department of Health and Mental Hygiene Brian J. Johnson - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Brian J. Johnson 25 May 2005 2159 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City Johns Hopkins-Bayview Baltimore
If Under 1 Year | If Under 24 Hrs. 6. Sex 1 ☐ M 2 ☐ F 8. Date of Birth (Month, Day, Year) 7-2-77 Birthplace (State or Foreign MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 27 Yrs Director 219-90-0455 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-f show amy injury or other treumatic event, the Medical Examinating be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Funeral Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 1621 Gwynn Fall Pkway USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 14 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No SpecifyBlack Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th Carpenter Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Karen Stewart James Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1621 Gwynn Fall PkwayBalto. MD 21217 Karen Stewart (mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. A □ Donation 5 □ Other (Specify) 6-3-05 Carmel Bundalk, MD 21. Signature of Funeral Service 22. Name and Address of FacilityWesley Chavis Jr. FH 2007 Eastern Ave. Balto. MD 21231 23a. Part1. Enter the disease or complications that caused the shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Mult burshot wounds DIE /Medical Due to (or as a cons vuence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4 Pregnant at time of death o 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☑ Yes 2 ☐ No 24a. Was an page 2 performed' 1 Xes 2 No Division of Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 5 Yes 2□ No 27. Manner of Death 28a. Date of Injury (Mont), Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Formal p 1 Natural 5 Pending Subject shot after death. 1 ☐ Yes 2 🔼 No investigation 5/25/05 2 Accident the 3 Suicide 4 Homicide 6 Could not be 28f. Location Street and Number or Rural Route Number, City or Town, State) 3500 BLK 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Dr sidewalk BaltimoreNID within 24 hours a

To the Funerel E

completely filled Shannon 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME Hallan nid May, 26, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 0 3 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** /Medical 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death If Under 1 Year If Under 24 Hrs. RIVERSIDE AR FORd RIEN 8. Date of Birth (Month, Day, Year) **Funeral** 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🖾 F Yrs. Director 139-44-0704 Usual Residence of Decedent the Maryland 10b. County 10d. Inside City Limits 10a State 10c. City, Town or Location If item 27 is marked other than "naturel", or iteme 23a or 28a-f ehow or other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Directo HARFORE PARTLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23a.c. any injury or other traumatic event, I'm Medicul Evaning must be once. 1123 BELT-AMP . 4 by Funeral 1016 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 € No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed ♣ ☑ Divorced WHITE Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 127 RS. GSAIRAI 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ MAILIGI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) KAHIDAY RA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State JUNEB 1 ☐ Burial 27 ☐ Cremation 3 ☐ Removal from State 1 4 □ Donation 5 □ Other (Specify) 2000 21. Sign to re Funer I Service Licensee 22. Name and Address of Facility 3/12/06 5/15/0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Pas 6 sagns tially list for differ if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner (or as a consequence of) The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of) Records, P.O. Box 68760 attending physician Physician/Medical esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy ŏ Month Year Day signed by the at Id be detached fo 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 🗆 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 24 No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 🗋 Accident investigation Director: 6 Could not be determined 3 🗌 Suicide in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 Mac Shaif 1 clune in 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Kell Cecilia 2005 : 20 une A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** n/a 8altimore Keswick 8. Date of Birth (Month, Day, Year) 1905 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Maryland 1□M 2☑F 216-46-7201 Director Usual Residence of Decedent Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other then "neturel", or items 23e or 28e-f show other treumetic event, the Medical Evanting min must be notified at 1 Tyes 2 No Director Baltimore Baldwin the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13816 Manor Glen Road 21013 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after in the of Health and Menta! Hygiene. Int: If Item 27 is marked other then "neturel", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2XXXIII Specify: 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own home Homemaker 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cecilia Christopher William Guckert ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia K. Reichart-daughter 13816 Maror Glen Rd., Baldwin, MD 21013 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any Injury or once. Most Holy Redeemer 6/6/05 Baltimore, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic Mee 22. Name and Address of Facility Ruck Touson Funeral Home, Inc. William G. Dau 1.050 York Rd., Towson, MD 2.1204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Finat disease or condition resulting in death) 9 ASTro INTESTINAL Pnysician 24 hours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and ned for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: signed by the attending be detached for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 Therusclerotic 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? BYLAST CANCEY 24a. Was an HISTORY After this certificate has autopsy performed? 2√Z No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2√ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of tniury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \( \text{Homicide} \) 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 35102 UM MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore KUAN DON 104 Tunbridg 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

			For State Registrar	State of Marylar		artment of H			giene Reg. No. 2	005	186	51.7	
	Physici /Medic		1. Decedent's Name (First, Middle, Las		$z\pi c$	•		2. Date of De Month		2005	3. Time of 945	Death A M	
	Examir Funeral Director		4a. Facility Name (If not institution, give Hell fage E/) 5. Social Security Number 6. Se Usual Residence of Decedent	street and number)  LOC  7. Age (In yrs.		4b. City, Town, o	If Under 24 Hrs. Hours Min.		th, Year)	nty of Death	ace (State of	r Foreign	
3altimore, Maryland 21215-0036	Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural" or Itams 23a or 28a-f show yo other traumatic event, the Modeal Examinar man be notified at ity or other traumatic event, the Modeal Examinar man be notified at	To Be Completed by Funeral Director	10a. State  10b. County  10e. Street and Number  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest graded)  17. Father's Name (First, Middle, Last)  19a. Informant's Name/Relationship (7)  20a. Method 5 Disposition  1 Burial 2 Cremation 3	12. Was Decedent Ever in UArmed Forces? 1 Yes, Give Year or Dates: ucation for completed) College (1-4or 5+)  200. Removal from State	16a. Dece (Give life.) 19b. Mailir 230 Place of Dispo	Nas Decedent of In 1974 to 1981. Specify Cubin In 1982 2 1986 In 1982 2 1982 In	ispanic Origin? (Stan, Movieth, Puerto Specify:  sation during most of work of the Community of the Communit	ing ne (First, Middle, H. Bal	16b. Kind of  Bolhin Maiden Sum  City or Tow	of What Count  SA  lace - America  Black, White, e  cify: WK  Business/Indu  WEE Ciff	n Indian, tc.  Fe ustry  Code)		
Baltin	permit. Pag Department Important: I any injury o		4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen.		Klawi	Name and Addre Bradler 2:34 W	ss of Facility  1 - Ash h	ON FUN SINING	eral Rd	Home 212	P.A.		
8760,	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):												
.O. Box 68	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 month? 1 □ Yes 2 1 No 9 □ Unknown	23c. If yes, outcome of pregni 1 \( \text{Live birth} \) 2 \( \text{Fate} \) 4 \( \text{Pregnant at time of c} \) 9 \( \text{Unknown} \)	ıl death 3 □	Ectopic pregnancy	,			Date of deliver Month E		ear	
Records, P	The law requires that the tee has been signed by the page 2 should be detached.	by	Part II. Other significant conditions of	entributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.		obacco use co Yes 2 □ No	ontribute to the		nknown	
al Rec		Completed						1 ☐ Yes	osy rmed? 2 No	prior to com death? 1 Yes 2	sy findings a pletion of ca	vailable use of	
ion of Vital	ding Phys h. After this funeral di	atlon: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manny of Death  1 V atural 5 Pending investigation	Hospital: 1 Inpatient 2 Inpatient 2 Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injun Wor	4 Privirsing no	h <i>(Check only d</i> ome 5 ☐ Resid 28d. Describe h	dence 6 🗆 O				
Division	spital or Atteniours after deatleral Diractor:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specil				28f. Location (S City or Tox	vn, State)			er,	
	To the Hospital or A within 24 hours after To the Funeral Dirac completely filled in by	<b>dedical</b>	(Check only 2 Medical Exem	sician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death	estigation, in my o	pinion, death occur	red at the time,	date and place	e, and due to t	ne cause(s)		
	T with	M	29b. Signature and title of certifier	4 July	M)	29c. Licens	e number		29d. Date sign	1/25	ay, Year)		
ı	Sta Registr	-	31. Date filed (Month, Day, Year)	32. Registrar's Signa	MCU atus	Ed. F	Me.	Xinde	16 142	2/	222	-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** OROP 26 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner H Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day, tuspital MOP Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 2 M 2 □ F 213-52 6 -4082 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or Items 23a or U.S.A 21220 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White ρ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: if flem 27 is marked other than "na any injury or other traumatic aven." Elementary/Secondary (0-12) College (1-4or 5+) 10 Manu om Dany 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ScheuerMan Nicholas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place EVelyN 20c. Location - City or Town, State Froy Date 20a. Method of Disposition 1 Burial 2 Teremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur - Funeral Service Scenses 22. Name and Address of Pacility

Bradky - Ash Home, P.A. 21222 tON FUNCEO WILLOW Spring 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical as a consequence of): Due to (a **Examiner** bronchopueumous Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed Yes 2□ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Minpatient 2☐ER/Outpatient 3☐DOA 1 Tyes 2 X No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

within 24 hours a To the Funeral C 9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Owusu-SAKyi UKLIN SqUARE DR. BALTIMORE Md 21237 DR. Jasephine 31. Date filed (Month, Day, Year) JUN 0 3 2005

29c. License number

D56381

29d. Date signed (Month, Dey, Year)

5-26-2005

Registrar

29b. Signature and title of 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amenditem//19a, per Inf. C844, 6/7/05 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2:30 PM M Henry DuBarry Knower 20 2005 May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 13841 Willoughby Road Upper Marlboro Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug 3, 193 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F Days 042-30-0307 72 1932 Alabama Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Mardical Examiner must be notified at once. 1 ☐ Yes 2 ☑ No Prince George's Upper Marlboro Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20772 13841 Willoughby Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 MYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify. Specify: white 156-58 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry DuBarry Knower Elizabeth riley Brooks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary Hankins Knower Rose Mary Knower/spouse 13841 Willoughby Road Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State \* 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sorvice Licensee Ronald S. Wade, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street State Anatomy Board 655 W.

Baltimore, MD 21201

23a. Partl. Enter the disease, of complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) Approximate Interval Between Onset and Death **Physician** Declestona mont disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Constiv Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate 20 No No No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 1 Yes 2 No P 2 ER/Outpatient 3□ DOA Hesidence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only within 24 one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D27904 newmon 30. Name and aderess of person who completed cause of death (Item 23a) (Type, Print) WARY M. NEWMAN

DHMH 17 Rev 1/2001

State

Registrar

10755

31. Date filed (Month, Day, Year)

JUN 03 2005

LUTHERVILL

#200

RD

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item #9 \$1516-131, 1985, 1208 b 2020 and 2020 a

			amend item #9 1- State Registrar	State of Maryland		TRACETT OF C			ene LNon n	given .
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Shirley Laird					2. Date of Death Month	-400	Year 3 Time of Death 7
	Examir		4a. Facility Name (If not institution, give s  North Arundel I			4b. City, Town, or Glen But			4c. County o	
	Funeral Director		5. Social Security Number 6. Sex		ast birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y		Arunde1  9. Birthplace (State or Foreign Country)  WD
			Usual Residence of Decedent  10a. State 10b. County		, Town or Loc	eation		Dec 23,	1921	10d. Inside City Limits
	the Man 28e-f sh	Director	MD Anne Arun	del	Pasade	1			011	1 ☐ Yes 2 ☐ No
	th with 23e or		757 203rd Street			10f. Zip Code 211	22	109	j. Citizen of Wi USA	nat Country?
036	72 hours after death with the Maryland netural; or Items 23e or 28e-f show Iteal Erroll with the Incillist at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	<ul> <li>12. Was Decedent Ever in U.S Armed Forces?</li> <li>1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:</li> </ul>	If	/as Decedent of His Yes, specify Cubar ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black,	- American Indian, , White, etc. white
215-0036	I within 72 hours lene. r then "netural", it e M. dies Ers	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give I	ent's Usual Occupa kind of work done di O NOT use retired)	urina most of work	ing 16	b. Kind of Bus	iness/Industry
N.	illec Hyg othe	Be Cor	unk 12 un 17. Father's Name (First, Middle, Last)	k		homemake <del>un</del> k		e (First, Middle, Ma	OWN 1	
yland	4 Cl -	To B	ABRAHAM GOLDSHII				ROSE	GRAFF		
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altimore,	Pages 1 and 2 should bent of Health and Mentint: If item 27 is marked ity or other treumatice		20a. Method of Disposition  1 ABurial 2 Cremation 3 Record (Specify)			ition (Name of atory or other place b Cenete	i	Date 20 05/2005 B		ity or Town, State
Balt	permit. Page Department of Importent: if eny injury or once.		21. Signature of Funeral Service License Ronald S. W	99 (//-	22. <b>St</b>		s of FacilitySo1	Levinson	& Bros.	Inc
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	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequent	7 \	1				
by A	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent		14				
28/00,	ficate be executed physician and ts the burial-transit		that initiated events c. resulting in death) Last	Due to (or as a consequent	ence of):					
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ecords, r	equires that en signed b	by	Part II. Other significant conditions conf	tributing to death but not resul	ting in the un	derlying cause giver	n in Part I.			ute to the cause of death?
	S S	Completed						24a. Was an autopsy performed	d? prid	ore autopsy findings available or to completion of cause of ath?  Yes 2 \sum No
ı vılaı	nysicier nis certif directo	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	R/Outpatient	3□ DOA Other		n (Check onlv one) me 5 ☐ Residenc	e 6 Other	(Specify)
	nding Pt ath. r: After the e funeral		27. Manner of Death 1 SNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work? M 1 \( \sup Y	at ? es 2 □ No	28d. Describe how	injury occurred	
NIN	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (Stree City or Town, S	t and Number State)	or Rural Route Number,
	P Hospil 24 hour Funer etely filk	edical	29a. Certifier 1 KCertifying Phys	ician: To the best of my know er: On the basis of examination and manner stated.	rledge, death on and/or inve	occurred at the time estigation, in my opi	o, date and place, nion, death occurr	and due to the caus ed at the time, date	e(s) and mann and place, and	er as stated. d due to the cause(s)
	To the To the compl	Me	29b. Signature and title of certifier	4.1 Dan		29c. License	number	29d.	Date signed (i	Month, Day, Year)
			30 Name and address of person who cor	mpleted cause of death (Item :	23 <b>6</b> ) (Type, P	rint) P	178		ay, 25	1 2003
	Sta	to	31. Date filed (Month, Day, Year)	3708 Hountain 32 Registrar's Signatu	Kood	, Vasade	na, MD	21122		
	Registr		IIIN 0 3 200		las	Me D				

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			1 - State Of IVIA Registrar		nent of Health and M cate of Death		0 0 0
				Certilic	cale of Dealif	Reg.	No. 115 865
н	Physici	an	Decedent's Name (First, Middle, Last)	1 301		Date of Death     Month	Day Year
	/Medic		Anna	Lieb		May	29 2005 4:30 PM
4	Examin	er	4a. Facility Name (If not institution, give street and number)	, /	City, Town, or Location of Death	/	4c. County of Death
			Cromwell NUVSING	Home	Dalhmore		
п	Funeral				Under 1 Year If Under 24 Hrs. hths Days Hours Min.	8. Date of Birth (Month, Day, Ye	
	Director		Usual Residence of Decedent	53 """		5.14.1	921 MAINS, PA
	and w			10c. City. Town or Location	1		10d. Inside City Limits
	Aaryl sho	5	MD RATIO	Dakin	. 1 -		1 □ Yes 2 ☑ No
	the N	Director	10e. Street and Number	- ACCUL	f. Zip Code	100	Citizen of What Country?
	with a or	급	2117 I. FINA ED	AIF	21234	109.	
	within 72 hours after death with the Maryland ene. than 'natural', or Itams 23a or 28e-f show Ita Madical Examilier must be notified at	Funeral I	11. Marital Status 12. Was Decedent E	ver in U.S. 13 Was f		offy Vac or No-	14. Race - American Indian,
	Itam Itam	Ę	1 Never Married 2 Married 1 Yes 2 No	If Yes	Decedent of Hispanic Origin? (Spe , specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
336	urs al	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1□Y	es 2 No Specify:		Specify: WHITE
21215-0036	2 hou	ed	15. Decedent's Education	16a. Decedent's	Usual Occupation	16b	. Kind of Business/Industry
15	s within 72 liene. r than "na	ple	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5-	ife DO NO	of work done during most of worki OT use retired)	_	
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D	be filed tal Hygid d other evant.	0	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Maid	den Sumame)
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Maryland	d 2 should th and Mer 7 Is marke traumatic	_	19a. Informant's Name/Relationship (Type, Print)		dress (Street and Number or Rura	al Route Number, Ci	ty or Town, State, Zip Code)
	and 2 lealth a m 27 ls		M. JOHN LIER . HUSBADD	2617 1	VENDOUTE AVE	- Pack	ILLE MD 2,234
Baltimore,	- I a =		20a. Method of Disposition	20b. Place of Disposition cemetery, crematory	(Name of	Date 20c	Location - City or Town, State
9	<u> </u>		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify) ☐ STONEMEN		6.3.	2005 R	ACTIMORE
量			21. Sign turn o Funeral Service Licensee		ne and Address of Facility		
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			shock, or heart failure. List only one cause on each life Immediate Cause (Final	э.	hurch mia	,,,	Interval Between Onset and Death
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Вох	atten for u	lan	in the past 12 months?	Petal death 3□Ector	pic pregnancy		23d. Date of delivery Month Day Year
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ō	w requ	Completed	Diffusion Remax	- Disacri		-	
ec	e law has b	npi	parkinson's Disc	order		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
=		Cor	/			performed 1 ☐ Yes 2 ☐	
Vital Record	Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		26. Place of Death	(Check only one)	
of \	8 S E	ပ	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatien			me 5 🗆 Residence	6 □Other (Specify)
	ng P	on:	27. Manner of Death 28a. Date of Injury 1 ☑Natural 5 ☐ Pending (Month, Day	Year) 28b. Time of Injury	Work?	28d. Describe how in	njury occurred
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	rs aff	Cer		<u> </u>			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier  (Check only   Certifying Physicien: To the best of 2   Medical Examiner: On the basis of a certifier   Medical Examiner: On the certifier   Medic	my knowledge, death occu	arred at the time, date and place, a	and due to the cause	e(s) and manner as stated.
	tha H hin 24 the F nplete	ledi	one) and manner stat	ed.			
	To To To To	Σ	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)
•			January m.	ソ	DO059855	J	INC 1, 2005
			36 Name and address of person who completed cause of de	ath (Item 23a) (Type, Print)	11 1 -	(1)	ine 1, 2005 e MD2/239
	10		Winglin GAO 560/ 1	och Rave	en Blvd, Bo	aldoman	e MV2/239
	Sta		31. Date lilad (Month, Day, Year) 32. Registrat	's Signature			
	Registr	ar	JUN O D TO THE PARTY OF THE PAR	1			

			1 - For State of M	aryland /	-	rtmen tificate			nd M		ene 3. No.2 ()	05	186	52
	Physici	an	Decedent's Name (First, Middle, Last)							2. Date of Death Month	Dav	_ Year	3. Time of D	eath
	/Medi		Tracy Locklear Jr.							May 31,	<sup>Day</sup> 200	5	0315	М
7	Examir	ner	4a. Facility Name (If not institution, give street and number)		1	_		Location of	Death			ty of Death		
			7026 Conley Street  5. Social Security Number 6. Sex 7. Ag	ge (In yrs. last bi	inthday)	Eas		If Under 2	4 Hrs.	8. Date of Birth	Balt	imor	e place (State or I	Enmina
	Funeral Director		217-66-5062 <sup>1</sup> XM <sup>2□</sup> F	51	Yrs.	Months	Days	Hours	Min.	06/18/1	953	Nort	h Carc	lina
	p ,		Usual Residence of Decedent  10a. State 10b. County	10- 0it T-										
	shov	5		10c. City, Tov		cation						1	10d. Inside City 1 ☐ Yes 2	
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	death ma 2	nera	11. Marital Status 12. Was Decedent Armed Forces		13. V			spanic Orig	in? (Spe	cify Yes or No- Rican, etc.)	14. Ra	ace - Americ	can Indian,	
98	or ite	by Funeral Directo	1 Never Married 2 Married 1 Yes 2	No		Yes 2		Specify:	Риепо г	nican, etc.)	Spec	ack, White,	etc.	
215-0036	within 72 hours after death with the Maryland ene. than "natural", or itema 23a or 28a-1 show the Medical Exami but must be multified at		3 ☐ Widowed 4 ☐ Divorced Year or Dates:									Ame	ricanI	ndia
7.	in 72 n "nai	piete	(Specify only highest grade completed)		(Give F	ent's Usua kind of wor OO NOT us	k done d	urina most	of workir	ng 11	6b. Kind of	Business/In	dustry	
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<u>ya</u>	Ments Ments arked attce	To	Tracy Locklear Sr.							Wilkin				
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р	ages nt of t: If it		1 Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of cemete										
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinational by notified at ance.		' 4 Donation 5 Other (Specify)  21. Sign Aur of Funeral Service Licenses	Uak I						2/05 Ba				
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8760,	/Medical Examine horizontal function and horizontal function and the private function and functi	ical Examiner	cause. Enter Underlying that initiated events c.	a consequence a consequence	of):								Interval Betwee	
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Records, P	quires that n signed t	Ş	Part II. Other significant conditions contributing to death b	ut not resulting i	n the un	derlying ca	use give	n in Part I.		23e. Did toba	cco use cor		ne cause of dea	
000	law requir as been si 2 should	Completed								24a. Was an	24b.	Were auto	psy findings av	ailable
R	The la	HO						_		autopsy performe	d? No	death?	mpletion of cau: 2□ No	se of
Vital	yaician: The is certificete hadirector, page	BeC	25. Was case referred to medical examiner?					26. Place o	of Death	Check on one	1110		20110	
of	F = F	은	1 yes 25No Hospital: 1 Inpatie  27. Manner of Death  Natural 5 Pending 2 Accident investigation  Hospital: 1 Inpatie (Month, Da		utpatient Time of Injury		Bc. Injury Work	4 LINUIS	2	ie 5 🗌 Resideni 8d. Describe how		-	Siste	r's nce
Division	al or Attanos after death	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inj building, et	ury - At home, fa c. <i>(Specify)</i>	arm, stre	et, factory,	office		2	8f. Location (Stre City or Town,	et and Num State)	ber or Rura	l Route Numbe	r,
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: Atter bompletely filled in by the fune	edicai (	29a. Certifier (Check only one) Certifying Physician: To the best 2 Medicel Exeminer: On the basis of and manner sta	f examination ar ated.	nd/or inve	estigation,	in my opi	nion, death	occurre	d at the time, date	and place,	anner as st , and due to	ated. the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c.	License	number		29d	. Date signe	ed (Month, i	Day, Year)	
•			I Relace V mer W	W		0	1838	8			6/1/	05		
1.	0		30. Name and address of person who completed cause of c	eath (Item 23a)	(Type, P	Print)	15	11	10		0			
7	)		31. Date filed (Month, Day, Year) 32. Paistr	ar's Signatur	06	make	10	itte	10/	1 717	37			
	Sta Registr		29b. Signature and title of certifier  30. Name and address of person who completed cause of cause of completed cause of completed cause of completed cause of caus	יאל לאנו	17									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Linda Lee Lex May 31 2005 06:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8304 Laiko Ct. Pasadena Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1□M 2∏F 57 Director 216-48-8021 5, 1947 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits item 27 is marked other than "naturel", or Items 23a or 28a-f show other traumatic event, the Medical Examinations to notified at 1 ☐ Yes 2 ☑ No Director MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8304 Laiko CT. 21122 Funeral <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na eny injury or other traumatic event, I'm Medic 2008. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 William Henry Shade Ethel Mary Hartine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Lex, Jr. / Husband 8304 Laiko Ct. Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Bullial 2 AFFrequention 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 2005 Catonsville, MD of Fundual Service Licensee 21. Signatu 22. Name and Address of Facility Kirkley-Ruddick Funeral Home P.A. 421 Crain Hwy. S.E. Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of) physician Box 68760 Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 2 No 2 12 No Division of Vital 1 🗌 Yes 1 Yes the Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ٩ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D31322 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4304 grow TAIN ROAD MO 32. Figistrar's Signatur 31. Date filed (Month, Day, Year) JUN 0 3 2005 Registrar

				St 1 - State Registrar	ate of Marylar	nd / Depa		of H	ealth and M	•	ene	)5 local
				Decedent's Name (First, Middle, Last)						2. Date of Death		3. Time of Death
		Physici /Medic Examin	al	Mildred Bertha Lyncl 4a. Facility Name (If not institution, give street			4b. City, To	own, or	Location of Death	May 31,	Day Y 2005 4c. County of	ear 2335 M
	1			Upper Chesapeake Med	dical Cente	r	E	3el			Harf	
		Funeral		5. Social Security Number 6. Sex 1 ☐ M	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo		Birthplace (State or Foreign Country)
	Н	Director		216-12-2206 Usual Residence of Decedent	x 83	113.				April 9,	1922	Maryland
		yland how		10a. State 10b. County	10c. Cit	ty, Town or Lo						10d. Inside City Limits
		8a-fs	ctor	Md. Harford			Bel Ai	ir				1 ☐ Yes 2 🙀 No
		be filed within 72 hours after death with the Maryland ital Hygiene. so other than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be notified at	Funeral Director	10e. Street and Number			10f. Zip C				. Citizen of Wha	at Country?
		eath v	eral	1401 Redfield Road  11. Marital Status   12. W	/as Decedent Ever in U	S 13 V	Was Decede	210			U.S.A.	American Indian,
35	(0	ifter d ir Item	Fun	A	med Forces?  ☐ Yes 2- No Yes, Give			_	spanic Origin? (Spe n, Mexican, Puerto	Rican, etc.)		White, etc.
2335	5-0036	ours a ral', o	by	3 □ Widowed 4 □ Divorced Y	Yes, Give ** ear or Dates:		1⊡Yes 21	Ľ No	Specify:		Specify:	white
B	5-0	"natu	Completed	15. Decedent's Education (Specify only highest grade con	n npleted)	16a. Deced (Give	dent's Usual kind of work	Occupa done d	tion uring most of worki	ng 16i	b. Kind of Busir	ness/Industry
	2121	withir ene. than	dmo		ollege (1-4or 5+)			retirea,			ntracto	r supplies
	9	filed Hygi other	Be Co	10 years 17. Father's Name (First, Middle, Last)		secr	etary		18. Mother's Name	(First, Middle, Ma		
	/lan	uld be Jenta rked rtic ev	To B	Lawrence Zorn					Julia Sc	hultz		
	Maryland	d 2 should be filed within th and Mental Hyglene. 7 is marked other than "fraumatic event, the Men		19a. Informant's Name/Relationship (Type, F						I Route Number, C		
3		1 and Health Sm 27 ther to		Howard M. Lynch/husl 20a. Method of Disposition	20h F	Place of Disno	sition (Name	a of	-	Bel Air,		15 ly or Town, State
5/31/05	Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		1 Burial 2 □ Cremation 3 □ Remov	val from State Ch	cemetery, crer urchvi urch C	natory or oth 11e Pr	er place	y•			
5/3	Ħ	artme ortan injuri	l Y	* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Ch	22	. Name and	Addres	s of Facility			11e, Md.
- 1	ñ	Deparenti Deparenti Import any ir	6 6	Buen a. W	elen		Schimu	ınek	Funeral	Home of	Bel Air	, Inc.
				23a. Part1. Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused the deat use on each line.	h. Do not ent	er the mode	of dying	, such as cardiac o	r respiratory arrest	'	Approximate Interval Between
		Pnysician	i N	disease or condition	Acute 1	Myoca	rdial	I.	rfareti	0+7		Onset and Death  4 minu fes
		/Medical Examiner		resulting in death)	Due to (or as a conseq	juence of):						
~			ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	juence of):						
72	4	cuted id ansit	Examiner	Sequential, list scrations, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
919	,092	ate be executed hysician and the burial-transit	Exc	resulting in death) Last	Due to (or as a conseq	(uence of):					_	
91 -	6876	cate b	dlcal	d						-		
#	Вох 6	leath certificat attending phy I for use as th	Physiclan/Med	IF FEMALE: 23c. If	yes, outcome of pregna	ancy					23d. Date o	f delivery
		death e atter d for u	iclar	in the past 12 months?	☐Live birth 2 ☐ Feta ☐ Pregnant at time of d		Ectopic preg Other <i>(spec</i>				Month	*
	P.O.	at the de by the a stached	hys	9 □ Unknown 9	Unknown							
		res tha igned be det	by	Part II. Other significant conditions contribu	ting to death but not res	ulting in the ur	nderlying cau	use give	n in Part I.			ite to the cause of death?
	Records,	w require been si should l	Completed								I,	Probably 4 Denknown
	Rec	ne taw s has t ge 2 s	ldm							24a. Was an autopsy performed	d? prio	re autopsy findings available r to completion of cause of th?
ec	Vital	ilcian: The contificate harector, page	e Co	25. Was case referred to medical					26. Place of Death	1 ☐ Yes 2 🗷	No 1 🗆	Yes 2□ No
9	Ž	ysician: is certific director,	To B	examiner? 1 Yes 2 No Hospit	al: 1 ☐ Inpatient 2 😉	R/Outpatien	t 3 DOA	Othe		ne 5 Residenc	e 6 Other	(Specify)
Mildred	n of	ting Ph I. After th funeral		27. Manne of Death  1 Natural 5 Pending	a. Date of Injury (Month, Day Year)	28b. Time of Injury	280	c. Injury Work	at 2	28d. Describe how		
	sio	tendio	catle	2 Accident investigation			М		es 2□No	201		
S.	Division	l or Attendi after death Director: A	ertification;	4 Homicide determined 28	e. Place of Injury - At he building, etc. (Specil	ome, farm, str	eet, factory, o	office	4	City or Town, S		or Rural Route Number,
-ynch,		spital nours neral / filled	O	29a. Certifier 1 Certifying Physician	: To the best of my kno	owledge, death	occurred at	t the tim	e, date and place, a	and due to the caus	e(s) and mann	er as stated.
1		To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	edical	(Check only 2 Medical Examiner: (one)	On the basis of examina and manner stated.	ation and/or inv				ed at the time, date	and place, and	due to the cause(s)
		To T To I	Σ	29b. Signature and title of certifier	mA		29c. I		number 350/2			Month, Day, Year)
		A		30. Name and address of person who comple	,	n 22a) /Tun-	Print)	<i>\(\begin{array}{c}\)</i>		)	1	nd. 21014
		~		J. Kevin Lyrv		2 /	VENT.	Z	Ave	Bel	Air,	nd. 21014
		Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature						
		Registr	ar	JUN 0 3 2005	Alexa 1	K San	de					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** 10:10 PM YCKENNU 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year If Under 24 Hrs. Months Days Hours Min. July 31, 1908 Uture Care Nursing Home Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** 218-22-202 1 M 2 1 F Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-1 show or other traumatic event, the Medical Exeminer must be notified a 1XYes 2 □ No Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? 23a MOR 1000 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2 should be filed within 72 hours afte and Mental Hygiene. Is markad othar than "natural", or I Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 □ Divorced BLACK Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER OTHGRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic evonce. BURDINE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CYNTHIA SKEENS GRAND-DACKHTED 4219 KENSING TON PD. PALTIHORE HD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State KINGMEM. PARK 06-01-05 WOODLAWN, 1 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 2140 North Fulton Avenue 21217 of Funeral Service Ligencee Joseph H. Brown Jr. Funeral 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** THEROSCLEROTIC CARDIOVASCULAR DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attanding Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760 Completed by Physiclan/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 4☐Pregnant at time of death Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 2 1 No 1 Yes 1 Yes Division of Vital within 24 hours after death.

To the Funeral Diractor: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide 1 Critifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medica 29b. Signature and titte of certifier 29d. Date signed (Month, Day, Year) 29c. License number JUNE, OI, 42510 2005 Vasantra(cuma MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)
JUN 0 3 2005

M. VASANTHA

32. Registrar's Signature

U 6 407

		for State Registrar	State of Maryl	and / Depa	artment of H	ealth and N	/lental Hygi	ene g. No. 20	05	1.8656
Physicia /Medic	al	Decedent's Name (First, Middle, Last)     Sara Carolyn Smi     4a. Facility Name (If not institution, give s			4b. City. Town, or	Location of Death	2. Date of Death Month 05	Day	Year 105	Time of Death 06:50pM
Examin Funeral Director	er	Kline Hospice Ho 5. Social Security Number 6. Sex	use	vrs. last birthday) Yrs.	Mt . Aj		8. Date of Birth (Month, Day, 03–28–	Fred	erick	(State or Foreign
	tor	Usual Residence of Decedent  10a. State 10b. County  MD Frederi		City, Town or Lo			00 20		j	Inside City Limits
th with the 23a or 28a	Funeral Director	10e. Street and Number 1494 West Ninth			10f. Zip Code	21771	10	g. Citizen of W USA	hat Country?	
should be filled within 72 hours after death with the Maryland and Mental Hygiene. Ind Mental Hygiene. Inarked other than "natural", or items 23a or 28a-f show umatic event, I're Moulcel Exercities marked to it.	by	11. Marital Status  1 □ Never Married 2√2 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 対 No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2█ No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Black	- American Ir k, White, etc. White	
be filed within 72 ho ital Hygiene. Id other than "natur event, Ira Modica	Completed	15. Decedent's Edui (Specify only highest grade Elementary/Secondary (0-12)		(Give life. (	lent's Usual Occupa kind of work done o DO NOT use retired etarial	during most of work	ding 1	6b. Kind of Bus Gov	siness/Industr erment	
2 should be filed within and Mental Hygiene. is marked other than aumatic event, Ira M.	To Be C	17. Father's Name (First, Middle, Last)  Melvin R. Smith					e (First, Middle, M le Carol	aiden Sumame	9)	
item 27 is main other trauma		19a. Informant's Name/Relationship (Type Donald Theodore)  20a. Method of Disposition	Madison/hus		g Address (Street a 494 West sition (Name of	Ninth St	. Freder:		21771	
permit. Pages 1 and 2 should Department of Health and I Important: If item 27 is marker any injury or other traumatic <u>once.</u>		1 ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Ponation 5 ☐ Other (Specify)  21. Signature of Funeral Service Liseope		cemetery, cren niform S ealth Sc	ervices ( iences Name and Addres	of the	/20/2005	Beth	esda,	
Physician /Medical Examiner	er	23a. Part1. Ent r the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Ibusease un ripury	cations that caused line?	eath. Do not ento	Rapp Fune 933 Gist er the mode of dyin	Ave Silv g, such as cardiac	er Sprin	g MD 20	Apr Inte	proximate eval Between set and Death
ires that the death certificate be executed signed by the attending physician and doe detached for use as the buriat-transit	edicai Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):						
the death certi y the attending iched for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pre 1	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery th Day	Year
w requ	Completed by P	Part II. Other significant conditions con	tributing de ot	resulting in t	verlyin, wuse give	en in Part I.	24a. Was an autopsy perform	24b. W	3 Probably	4 Unknown
ng fter	ation: To Be	25. Was case referred to medical examiner? 1   Yes   25   No	lospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yee	2 ER/Outpatien 28b. Time of Injury	28c. Injun Work	er: 4 🗆 Nursing Ho	th (Check only one ome 5 Resider 28d. Describe how	ice 6 othe	or (Specify)	Holled
To the Hospital or Attending within 24 hours after death of To the Funeral Director: After completely filled in by the fune	il Certification:	3 Suicide 4 Homicide  6 Could not be determined	28e. Place of Injury - / building, etc. (Sp	pecify)		ne, date and place	28f. Location (Stre City or Town,	State)		
To the Hos within 24 ho To the Fun completely	Medical	(Check only one)  26 Medical Examinone)  29b. Signature and title of certifier	ner: On the basis of exar and manner stated.	nination and/or inv	vestigation, in my of	pinion, death occur	red at the time, dai	te and place, and that the and place, and de	nd due to the	cause(s)
J,		30. Name an addry's of person who co	months tause of death	(Item 23a) (Type, St. Fred	Print)	21701	2	May	(21)	atos
Sta Registr		Ali Afrookteh 30 31. Date filed (Month, Day, Year)	00 West (th	ignaty						

			For State Registrer	State of Mary		artment of rtificate of			giene	5	8657
	Dhysici	an'	1. Decedent's Name (First, Middle, Last	)				2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physici /Medic		Robert Louis Mox					May	31 2	005	2:00 A M
	Examir	ier	4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Death			y of Death	
	. B		5234 Arbutus Avei 5. Social Security Number 6. Se		yrs. last birthday)	If Under 1 Year	Arbutus	O Date of Ries		altim	
	Funeral Director		217-46-2861	<i>x</i>	56 Yrs.	Months Days		8. Date of Birth (Month, Day Jun. 1	5, 1948	Mar Mar	lace (State or Foreign itry) yland
	and w		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	ocation				1	0d. Inside City Limits
	Mary f sho	tor	MD Balti	nore	A	Arbutus					1 ☐ Yes 2 🎇 No
	r 28e	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	itry?
	th wit	alD	5234 Arbutus Ave	nue			21227		Unite	d Sta	tes
	Items Items	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No-	14. Ra	ce - Americ	
36	or It		1 ☐ Never Married 2X Married	1 X Yes 2 ☐ No If Yes, Give 1	10 26 67	1 ☐ Yes 2X No		, , , ,	Specia	T.Th	ite
8	72 hours after death with the Maryland naturel', or Items 23s or 28e-1 show Jinel Exam at must be coilified at	d by	3 Widowed 4 Divorced	Year or Dates: 1	2-13-71						
Maryland 21215-0036	be filed within 72 hours after death with the Marylar ital Hyglene.  do other then "naturel", or items 23s or 28e-1 show other then "naturel", or items 23s or 28e-1 show svent. The Medical Examinet must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	'e completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of work	ring	16b. Kind of B	dusiness/Inc	dustry
12	filed within Hygiene. wher then ont. I've We	omo	Elementary/Secondary (0-12)	College (1-4or 5+)		Laborer	/		Ware	house	
b	should be filed with a Mental Hygiene marked other the matic svent, Last	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,			
<u>a</u>	Aental Aental rked o	To B	Joseph J. Mox				Cathe	rine Sur	nmers		
ary	d 2 should be th and Mental 7 Is marked of traumatic sve	-	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Maili	ng Address (Stree	t and Number or Run	al Route Numbe	r, City or Town	, State, Zip	Code)
	27 E		Marie E. Mox Wit				Ave., Arb		21227		
Baltimore,	of of the second		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	Ob. Place of Dispo cemetery, crei	sition (Name of matory or other pla	ace)	Date	20c. Location	- City or To	wn, State
Ë	Pages ment of I ant: If it		' 4 □ Donation 5 □ Other (Specify)	ω   I			, Inc. 6-		Balti		
3ali	permit. Pag Department Important: Il eny injury o		21. Signature of Funeral Service Licens	en Mil			ess of Facility Am				
	0.0 = 0 0		23a. Part1. Enter the disease, or comp	(1004 4)			ur Spring			MD 2	1227 Approximate
	Pnysician /Medical Examiner		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.  a. META STA  Due to (or as a co	ITIC 5		us cana			uth_	Interval Between Onset and Death
)0°,	cate be executed physician and the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co							
8760,	ate b hysic the bi	llcal		d							
.O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 Live birth 2 C 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnanc	cy			ite of delive	ry Day Year
0	res that t igned by be detar		Part II. Other significant conditions co	ntributing to death but no	ot resulting in the u	nderlying cause g	ven in Part I.	23e. Did to	bacco use con	tribute to th	e cause of death?
rds	quires n sign	d by						1 <b>X</b> Y	es 2 🗆 No	3 🗆 Prob	ably 4 ∐Unknown
Records,	aw requir ts been si 2 should	Completed						24a. Was a			osy findings available
Re	9 4 9	mo						autop: perfor	med?	death?	npletion of cause of 2 No
Vital		a	25. Was case referred to medical				26. Place of Deatl				2 110
of V	ys diis	To B	examiner? 1 ☐ Yes 2 No	lospital: 1 Inpatient	2 ER/Outpatier	nt 3□ DOA Ot	her: 4 Nursing Ho	me 5 Resid	ence 6 Oth	ner (Specify	)
		ë.	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time o		iry at ork?	28d. Describe h	ow injury occur	red	
sio	Attending r death. sector: After by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2□No				
Division	el or Attend s after death of Director:	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str pecify)	eet, factory, office		28f. Location (S City or Tow		ber or Rurai	Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dire completely filled in b	Medical (	29a. Certifier (Check only one) Certifying Phy	sicien: To the best of moner: On the basis of exa and manner stated.	y knowledge, deatl mination and/or in	n occurred at the t vestigation, in my	me, date and place, opinion, death occurr	and due to the cred at the time, d	ause(s) and ma date and place,	anner as sta	ated. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	10 110			se number		29d. Date signe		
•	1		· Culle	sue MI)		D /	6354	J	WE	1,2	005
	6		30. Name and address of person who co		0	Print)	6354 WE BAL	Timno	E JIA	2 /	1 10
			31. Date filed (Month, Day, Year)	AGNES 32 Registrar's	900 C	HIGN /	TVE DIT	1117010	E MD	$\propto 1$	227
	Sta Registr		IIIN 0 3 20	05 32 Registrar's	Dr M						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** May 31, Philip I. Miller 2005 9:25 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Gilchrist Center Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 1950 Director 217-54-6438 55 May 8, Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c, City, Town or Location 10d. Inside City Limits 10a State 77 is marked other then "naturel", or Items 23a or 28e-1 show treumatic event. The Middeal Examiner must be nutified at 1 ☐ Yes 2 X No Directo MD Baltimore Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 7134 Greenwood Avenue 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌣 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) /Operating Systems Mgr. Bank of America 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other treumatic event 900g. Ivan J. Miller Della Bender 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene F. Miller/wife 7134 Greenwood Ave., Baltimore, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dulaney Valley Mem. Grdns. 1 ■ Burial 2 □ Cremation 3 □ Removal from State
'4 □ Donation 5 □ Other (Specify) Timonium, Maryland 21. Signature of Funeral Service Licensee Ruck Towson Funeral Home, Inc. 22. Name and Address of Facility 1050 York Road, Towson, MD. 21204 5. Coster 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** metastatic Colon concer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit nding physician and resulting in death) Last Due to (or as a consequence of): by Physiclan/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? signed by the atten d be detached for u 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2. No 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) + 5 S (Ce 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 🛣 No this 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funerel Director: After th
completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 025205 June 2, 2005 N. Charles St. Balto md 21204 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 6 BMC A. Ril 6701 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			For	State of Ma		epartment of Hea		•	ne combie.	
			1 - For State Registrar		•	Certificate of De		Reg. I	71115	18659
	Physici	an	1. Decedent's Name (First, Middle	, Last)				Date of Death Month	Day Year	3. Time of Death
	/Media	cal	William  4a. Facility Name (If not institution	Randolph	Moats	th City Town or Los		une 1	200	3 2
	Examir	ier	Franklin Sou	ore Hosf	ital	4b. City, Town, or Loc ROSEd	ale	1	4c. County of Dea	mose
	Funeral Director		5. Social Security Number 226-46-6192	6. Sex 7. Ag 1 🔀 M 2 🗆 F	e (In yrs. last birl		ours Min. 3	Date of Birth (Month, Day, Yea UNC 30 1	9. Bin C	rthplace (State or Foreign ountry)  VA
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show fre Madical Erection must be notified at	by Funeral Director	Maryland	N/A			altimore			1 X Yes 2 No
	with the or 2	Dire	10e. Street and Number			10f. Zip Code	1.004	10g. (	Citizen of What C	ountry?
	death w	era	555 G South ma	12. Was Decedent	Ever in U.S.	13. Was Decedent of Hispar If Yes, specify Cuban, M	1221 nic Origin? (Specify	Yes or No-	USA 14. Race - Am	erican Indian,
· ·	aftar or Iten	Fun	1 Never Married 2 Marr	Amed Forces? ed 1 ☐ Yes 2 ☑ 1				ın, etc.)	Black, Whi	
10-M	"naturel",	d by	3 Widowed 4 XDivorced	If Yes, Give Year or Dates:	1 100		pecify:			White
0 0 4	n nat	Be Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12)	t grade completed)		Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	g most of working	16b.	. Kind of Business	l/Industry
_ 25	ad with giene er tha	Com	6	College (1-4or 5	0+)	Contractor			ome Impro	vement
1,	should be filed within the Marked other than marked other than imatic event, the Market than than the Market t	Be	17. Father's Name (First, Middle,				Mother's Name (Fi			
Waryland	2 should I and Meni Is marke	은	John Floyd  19a. Informant's Name/Relationsi	Moats	19b.	Mailing Address (Street and I			MMONS	Zin Code)
	1 and 2 s Health ar tem 27 is		Mabel Hatcher	(sister)		oute 250, McDo			, 0. 70, 0.0.0,	
1000	ges 1 and 2 should be filed within 72 hr to t Health and Mental Hygiene. If item 27 Is marked other than "natur or other traumatic event, the Medical	L 69	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from State	20b. Place of cemeter	Disposition (Name of y, crematory or other place)	June	05 <sup>20c.</sup>	Location - City or	Town, State
0	permit. Pages Department of 8 Importent: If its any injury or of		' 4 ☐ Donation 5 ☐ Other (S)	pecify)	McKend	ree Cemetery	2005		owell, \	
$\leq \overline{a}$	permit. Pa Departmen Importent: any injury once.		21. Signature of Funeral Service	Licensee		22. Name and Address of 3111 Mounta	000	llings F Fasader	uneral F a, MD 21	lome, P.A. 122
			23a. Part1. Enter the disease, or shock, or hear allure. List	con lications (b) t caused on the cause on each li	the death. Do n	ot enter the mode of dying, su	ich as cardiac or res	spiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Va Ventri		Fibrillati	61			Griser and Death
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14/	bed .	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence o	rf):				
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Box 68760	icate be ex physician s the burial	dical		d						
X G	onding p	υ/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of de	livery
	he death certit	Physiclan/Med	in the past 12 months?  1  Yes 2 No 9 Unknown	1□Live birth 4□Pregnant at 9□Unknown	2 ☐ Fetal death time of death	3 □Ectopic pregnancy 5 □ Other (specify)		<u> </u>	Month	Day Year
0	uires that the danger signed by the	by Phy	Part II. Other significant condition	ns contributing to death b	ut not resulting in	the underlying cause given in	Part I.	23e. Did tobacco	o use contribute t	o the cause of death?
ords	w require been sig should b	ted b	Small Bon	e1065	truct	100		1 🗆 Yes	2 □ No 3 □ P	robably 4 Unknown
Division of Vital Records	Attending Physicien: The law requires that the death certilicate refault.  Attending Physicien: The law requires that the death certilicate setor; there this certificate has been signed by the attending phys by the tuneral director, page 2 should be detached for use as the	Completed	Hithesion M	id JeJur	ILM			24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
<u>=</u>	ding Physicien: The h. Atter this certificate h. Iuneral director, page	BeC	25. Was case referred to medical examiner?				Place of Death (Ch	neck only one)		
of C	Physi this c	2 1	1 Yes 2 No	Hospital: Inpatie			□ Nursing Home	5 Residence		ecify)
	rding F th. : Atter s tunera	ıtlon	1∠Natural 5 Pendin 2 Accident investig		y Year) Ir	irne of pjury at work?  M 1 Tyes		Describe flow III	july occurred	
ivio	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tu	Certification:	3 Suicide 6 Could r 4 Homicide determ		ury - At home, far c. (Specify)	m, street, factory, office	28f.	Location (Street City or Town, Sta	and Number or R	ural Route Number,
_	ospital hours a unerel		29a. Certifier 12 Certifyin	Physician: To the best	of my knowledge	death occurred at the time, dated	ate and place, and	due to the cause	(s) and manner as	s stated.
	o the Figure 124	Medical	one)  29b. Signature and title of pertifier	and manner sta	ated.	29c. License nur			Date signed (Mg/si	
	- s + ō		you y	alburt,	M.D.	DOC	15867	7/	6/1/0	5
-	1)		30. Name and address of person	who completed cause of d	eath (Item 23a) (	Type, Print) Lace Drive	e Bolt	imore	MP	21237
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 3 20	2. Registra	ar's Signature	land o			, ,	
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			1 - For State Registrar	State of Mar		partme e <i>rtifica</i>			ind Me		ene	005		
	Physici /Medic		Decedent's Name (First, Middle, Last)     WILLIAM MUSELEI							2. Date of Death Month MAY	Day	Year 2005	3. Time of De 10:15	P M
	Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City	, Town, or	Location of	f Death		4c. County	y of Death		
			HERITAGE HARBOUR I				NAPOL				ANN	E ARU		
	Funeral Director		5. Social Security Number 6. Sex 082.05.1652	IM 2□F	In yrs. last birthda 96 Yrs.	Months	er 1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, JUNE 1,	<sup>Year)</sup> 1908	9. Birthp Coun GERI	lace (State or F try) MANY	oreign
	iges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene.  If itsm 27 is merked other then "naturel", or items 23e or 28e-f ehow or other treumatic event, the Medical Example must be positived at	Director	10a. State 10b. County  MD ANNE ARUI  10e. Street and Number		Oc. City, Town or	S	ip Code			10	g. Citizen of		0d. Inside City I	
	23e	rai	85 MANRESA RD				21401				USA			
9000	nours after de: urel', or items I Examinar m	d by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 Pes 2XXVo If Yes, Give Year or Dates:		1 🗆 Yes	2□ No XX	Specify:	in? (Spec , Puerto F	cify Yes or No- Rican, etc.)		ce - Americ ck, White, y: WHI!	etc.	
21215-0036	within 72 h ene. then "natu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) Coltege (1-4or 5+)	(Gi	cedent's Usi ve kind of w b. DO NOT	ork done d	urina most i	of workin	19	6b. Kind of B	usiness/Ind	lustry	
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	1 and 2 sh Health and ism 27 is rr other treum		19a. Informant's Name/Relationship (Type WILLIAM MUSELER	SON	828	CHES	TER A			Route Number, LIS, MD	-	State, Zip	Code)	
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	ne Hospitel n 24 hours ne Funeral pletely filled	Medical (	29a. Certifier (Check only one)  XX Certifying Physical Control (Check only one)	ician: To the best of n ar: On the basis of ex and manner stated	amination and/or	ath occurred investigation	at the time	e, date and nion, death	place, ar	nd due to the cau d at the time, dat	ise(s) and ma e and place, :	inner as sta and due to	ited. the cause(s)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ean 3: 00 AM venc 0 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Toyy, or Location of Death Examiner DALTIMORE HAZELWOOD 8. Date of Birth (Month, Day, **Funeral** 6. Sex 7. Age (In yrs. last birthday) 85 Days Months 1 □ M 2 1 Yrs. Director death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other traumatic avant, the Mudical Examinar must be notified at ATIMORE 1 Yes 2 No Completed by Funeral Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or Items 23e 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Race - American Indian, Black, White, etc. 11 Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Ite 1 ☐ Yes 2 🗹 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) HOME MAKEX 17. Father's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Number or BATO, NO 21206 20c. Location - City or Town, State HAZEL NOOD 10ULTON CAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department o Important: If any injury or once. 22. Name and Address of Facility VAUCHIN C. GREENE FUNERAL HOME ' 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee YORK ROAD BALTIMORE, MARYCAND 2/2/2 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Dellina **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medicai Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but rowesulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No funeral director, page 2 should Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 1 TYAS 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Tyes 2 No Certification: To 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No after death 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10 2012 205

State Registrar

1202E 31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUN 03 2005

30. Name and address of person who completed cause

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death (Item 23a) Type, Print) 08 11 DO(N+

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Registrar

31. Date filed (Month, Day, Year)

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2005

P.O. Box 68760,

Division of Vital Records,

32. Segistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item #11 per vrife 845 7/7/2005 and State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** Nicholson 322 AM Kay thirtieth /Medical Facility Name (If not institution, give street and number) 46. Giff, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. Social Security Number If Under **Funeral** 7. Age (In, rs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min 12 M 2□F Yrs. Director 34 218-92-5959 04/21/1971 MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is markad othar than "natural", or items 23s or 28a-f show othar traumatic avant, the Madical Examinar must be notified at 1 Yes 2 No MD Baltimore City Direct Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with Funeral 837 E. Jeffrey St 21230 United States Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. hours after ☐Yes 2XNo Yes, Give 1 Never Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene. Agriculture Elementary/Secondary (0-12) College (1-4or 5+) Landscaper 12 permit. Pages 1 and 2 should be flik Depurtment of Health and Mental Hy Important: If Itam 27 Is marked oth any njury or other traumatic avant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ray Eugene Nicholson, Sr. Connie Woodward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie Howell-Olo/ mother 132 Northway Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Jun 3 \* 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory Inc. 2005 22. Name and Address of Facility Stell Dohnnam MO0382 Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Acrtic Dissection 14 days /Medical Due to (or as a consequence of) **Examiner** Multiple Oracus Dysfunction Syndrame Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 lan/Medical the as IF FEMALE esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year Physic 4 Pregnant at time of death 5 Other (specify) P.O. the 1 ☐ Yes 2 No 9 ☐ Unknown 9□ Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2 X No 2 X No 1 Yes 1 Yes Hospital or Attanding Physician; 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To tha Funaral Dirac 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ca (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year, MD May 30, 2005 RES - 000 Meschlis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Catherine 600 North Wolfe Street Baltimore Meschlez MD 31. Date filed (Month, Day, Year) Aegistrar's Signature

State

Registrar

JUN 0 3 2005

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,00,	Physician be executed attending physician and attending physician and for use as the burial-transit	dical Examiner	23a. Part 1. Eyer the disease, or of shock, or leart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as detection of the control of the co	a conseque a treva a conseque	nce of):								Approxim Interval I Onset ar	Between nd Death
O. BOX 68	at the death certifical by the attending phi tached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₺ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal d	leath 3	Ectopic pred Other (spec					1	Date of delimental	very Day	Year
cords, P.	w requires that to be signed by should be detailed		Part II. Other significant condition	s contributing to death bu	ut not result	ing in the u	nderlying cau	ise giver	n in Part I.			ebacco use co			
итат жесс	The law ate has b page 2 sl	e Completed	25. Was case referred to medical						26 Place	of Death	24a. Was autop perfor 1 Yes	sy med? 2 No	prior to c death?	topsy findin ompletion o	gs available i cause of
0	ing Phys	ation: To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investig:		ry 2	R/Outpatien 8b. Time of Injury		Other	4 □ Nu	rsing Hom	e 5 Resid	lence 6 🗆 C		eify)	
DIVISION	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the tu	Certification:	3 Suicide 6 Could no 4 Homicide determin	building, etc	c. (Specify)						8f. Location (S City or Tox	m, State)			lumber,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier (Check only 2 Medical E one)  29b. Signature and title of certifier	Physician: To the best of xaminer: On the basis of and manner sta	examination	ledge, deatl on and/or in	vestigation, in	the time n my opi License	nion, deat	d place, a	d at the time,	cause(s) and date and place 29d. Date sign	e, and due	to the caus	
)	⊢s⊢ŏ		30. Name and address of person w	no completed cause of d	eath (Item 2	23a) (Type	Print)	17	749	1			-05		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)		GIE EL	te. You	512	- D	Ba	Iture	,-e M	D 21	202		

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or	Print in	Black	Indelible Ink.	Ensure	All	Copies	Are	Legible

		For	State of Maryland /	Depa	rtment of H	ealth and M	•	_	05	10007
		1 - Stete Registrar		Cer	tificate of l	Death		g. No.		1000/
Physici	an	1. Decedent's Name (First, Middle, Las Elva Quarles	•				2. Date of Death Month	Day	Year	3. Time of Death
/Medio		4a. Facility Name (If not institution, give			4b. Cîty, Town, or	Location of Death	May	4c. County		ZOD) IT
LXGIIIII		Doctors Community	Hospital		Lanham		8. Date of Birth (Month, Day,		ice Geo	orges
Funeral Director		5. Social Security Number 6. Se 218–14–5169	7. Age (In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	9. Birthplac Country Ralti	ce (State or Foreign y) More, MD		
	Funeral Director	Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	vn or Loc	cation		04/06/19			d. Inside City Limits
Maryli		MD Prince			rlboro					* Yes 2 □ No
or 284		10e. Street and Number			10f. Zip Code		10	g. Citizen of V		
eath v	erai	13310 New Acad	1a Lane  12. Was Decedent Ever in U.S.	13 V	20774	ispanic Origin? (Spe	cify Ves or No-	United	es n Indian,	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exatt and must be notified at once.	by Fun	1 □ Never Married 2 □ Married  ** Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Yes, specify Cuba  ☐ Yes 2☐ No	ispanic Origin? (Spe n, Mexican, Puerto Specify:	Rican, etc.)	Specify	C.	
72 hou nature	Completed k	15. Decedent's Ed (Specify only highest grad	ucation 16a	. Deced	ent's Usual Occupa	ation during most of worki	na 1	6b. Kind of Bu Baltim	Black	
within ene. than "		Elementary/Secondary (0-12)	College (1-4or 5+)		cher	during most of worki )		Public		-
i Hygi other	Be Co	17. Father's Name (First, Middle, Last)	3 yrs	TCu	Chei	18. Mother's Name				)15
Menta Menta Brked Stic ev	ToB	John Minnis				Elva Ma	e Diggs			
nd 2 sho lith and 27 ie mu traum		19a. Informant's Name/Relationship (7 Barbara Hayden/				and Number or Rura Od Drive				
es 1 ar of Hea fitem 3 r other		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	20b. Place o	of Dispos	sition (Name of latory or other plac			Oc. Location -		
t. Pag tment tant: f		* 4★ Donation 5 Other (Specify	Howard	d Me	dical Sc	nool May	11,2005	Washii	naton.	DC
permii Depar Impor any ir		21. Signature of Funeral Service Licen.	jee		Austin Ro	öyster Fu	neral Ho	me		
		23a. Part1 Enter the disease, or comp shock, or heart allure. List only of	lications that caused the death. Do	not ente	3821 1401 or the mode of dying	n St. NW I g, such as cardiac o	Washingt r respiratory arre	on, DC	A	Approximate nterval Between
Physician		Immediate Cause (Final disease or condition	a Acute Gastro I							Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequence	of):						
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Lung Mass Poss1	ible of):	Lung Car	icer				
be executed sician and burlal-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Colon Cancer  Due to (or as a consequence	of):						
ite be ex iysician ne burla	ical E		d. Chronic Renal 1	,	fficiency	/				
artifica ing ph e as th	장	IF FEMALE:	23c. If yes, outcome of pregnancy							
The law requires that the death certificate be executed its has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No		23d. Date of delivery Month Day						
res that the de igned by the a be detached		9 ☐ Unknown  Part II. Other significant conditions co	untributing to death but not resulting	in the un	derlying cause give	en in Part I.	23e. Did toba	ribute to the	cause of death?	
v requires been sign should be	ed by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						21 No	3 🗌 Probab	oly 4 Unknown
a law re as be be 2 sho	Completed						24a. Was an autopsy		prior to comp	y findings available pletion of cause of
		05 West and the section					perfórm 1 ☐ Yes 2°	No 1	death?	□ No
ysicia is certi directo	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No	Hospital: 1 ★npatient 2 ☐ ER/O	utpatient	3□ DOA Cthe	26. Place of Death			er (Specify)	
or Attending Physician: after death. Director: After this certific in by the funeral director.	J: L	27. Manner of Death 1 ★ Natural 5 □ Pending	28a. Date of Injury 28b.	Time of Injury	28c. Injury Work	at 2	28d. Describe how			
Attendii death. ctor: A y the fu	catio	2 Accident investigation 3 Suicide 6 Could not be				res 2□No	204 1 104-			
tal or At rs after o ai Direc ed in by	Certification:	4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, stre	et, factory, office		28f. Location (Stre City or Town,		ar or Hurai H	foute Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1  Certifying Phy (Check only 2 Medicel Exam	/sicien: To the best of my knowledge iner: On the basis of examination ar and manner stated.	e, death nd/or inv	occurred at the timestigation, in my op	e, date and place, a pinion, death occurre	and due to the cau ad at the time, da	use(s) and ma le and place, a	nner as state and due to th	ad. ne cau <i>s</i> e(s)
To th within To th	M	29b. Signature and title of certifier	ella MD		29c. License		29	d. Date signed		y, Year)
/		20 Nome		/T: 5		59981		217		
り		30. Name and address of person who c	Apole 11a, v			ndover Ro	ad Suite	e #3 Ch	everl	y,MD 20785
Sta Registr		31. Date filed (Month Day, Year) 200	5 Registrar's Signature	has						

					aryland / Depa				_	
			1 - For State Registrar			rtificate of			2 U U 5	8668
	Physici	an	1. Decedent's Name (First, Middle,	Last)	-			2. Date of Deat Month	h Day Year	3. Time of Death
	/Medi	cal	William Frederick I			4. 6. 7		05	29 200	5 10:48 PM
4	Examir	ner	4a. Facility Name (If not institution, g				r Location of Death		4c. County of Dea	
	Funeral	-	11423 Raphel Ro 5. Social Security Number 6	. Sex 7. Ag	ge (In yrs. last birthday)	Upper tf Under 1 Year	tf Under 24 Hrs.	8. Date of Birth (Month, Day,	Baltim 9. Bi	Ore irthplace (State or Foreign Country)
	Director		213-38-6565	1 <b>X</b> M 2□ F	65 Yrs.	Months Days	Hours Min.	09/21/1		aryland
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. tnside City Limits
	Mary a-f sh	tor	MD Balt:	imore	Upper Fa	alls				1 ☐ Yes 2X No
	or 284	Funeral Director	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What C	ountry?
	s 23a	ral	11423 Raphel Ro			21156			U.S.A.	
	ter de item	-une	11. Marital Status  1 □ Never Married 2 □ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔀	No. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
036	rel', or	b	3 ☐ Widowed 4 💆 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	hite
15-0	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or items 23a or 28a-f show int, Ite Medicel Exerting Frant be multiful	Completed	15. Decedent's (Specify only highest	Education grade completed)	(Give	dent's Usual Occup kind of work done	during most of worki	ing	6b. Kind of Business	s/Industry
121	filed within Hygiene. rther than ant, ILE ME	dmc	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use retired			Crancian A	
d 2	be filed within tal Hygiene. Ind other than event, the Missent.	Be C	17. Father's Name (First, Middle, La	st)	Macı	nine Oper	18. Mother's Name		Grumman Ad Maiden Surname)	erospace
ylar		To E	Austin William	Raspe			Eleanor	Elizabe	th Petry	
Maryland 21215-0036	12 sho	6 93	19a. Informant's Name/Relationship	, ,, ,	0.00000	ng Address (Street	and Number or Rura	al Route Number,	City or Town, State,	Zip Code)
	s 1 and 2 should f Health and Mer item 27 is marke other treumetic		Elizabeth L. S  20a. Method of Disposition	Sullivan (d	20b. Place of Dispo	123 Raphe	1 Road - I	Upper Fa	11s, Mary 20c. Location - City of	land 21156
mo I	Pages ent of I nt: If its ry or o		1X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe						Bel Air, 1	
Baltimore,	permit. Pages Department of H Importent: If ite any injury or of		21. Signature of Funeral Service Lic		DEI AII I	2. Name and Addre	ss of Facility E.	F. Lass	ahn Funer	Maryland al Home, P.A.
8	Dep fine any		16.30	assalm	11	1750 Bela	ir Road —	Kingsvi	lle, Mary	land 21087
١,		1	23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that caused by one cause on each li	d the death. Do not ent ine.	er the mode of dyin	ng, such as cardiac o	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Finat disease or condition resulting in death)		rcimona wit	h Metast	asis			Yr
	Examiner				a consequence of):	himsomto	uc			Yrs
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89	5 × 5	edi		d.						
Вох	death certifica e attending ph id for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		23d. Date of de				
Ю. В	the dea y the at sched fo	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
<u>α</u>	that the de ned by the a detached f		Part II. Other significant conditions	contributing to death b	out not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute t	to the cause of death?
Records,	igr be	ed by	Pneumo Thorax					1 🗆 Yes	s 2□No 3□P	robably 4 X Unknown
eco	law as b	Completed	Pneumonia					24a. Was an		utopsy findings available completion of cause of
Ä	Th ate pag	Com						perform	ad?   death?	s 2 No
Vital	Physician: this certifica ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		t all poor Other	26. Place of Death			
of		1; To	1 ☐ Yes 2 X No 27. Manner of Death	1 ☐ Inpatie	ent 2 ER/Outpatien	I 3 DOA	4   Nuising Hor	ne 5 🔀 Resider 28d. Describe hov	nce 6 Other (Spe	cify)
ion	Attending Property of death.  Sector: After by the funera	atlor	1 XNatural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Da	y Year) Injury	Worl			,,	
Division		ertification;	3 ☐ Suicide 6 ☐ Could not determine		ury - At home, farm, str. c. (Specify)	eet, factory, office	2	28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
	Hospitel or 24 hours afte Funerel Dir tely filled in	O	200 Cartilla 177 C				<u> </u>			
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best aminer: On the basis of and manner sta	of my knowledge, death f examination and/or inv ated	occurred at the time time of the stigation, in my of	ne, date and place, a pinion, death occurre	and due to the car ed at the time, da	use(s) and manner a te and place, and due	s stated. a to the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	0.0	1	29c. License	e number	29	d. Date signed (Mont	h, Day, Year)
			• Allen	ree	ry MIL	D547	49		06/01/200	)5
	1		30. Name and address of person wh			,				
	Sta	te	Allen Reilly, M 31. Date filed (Month, Day, Year)	32. Registr	House Av	•	- Freder	ick, Mar	yland 21	701
	Registr		JUN 03	2005	en It s	( Sheet				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Physician 30 DM MALCOLM ROJAS 12 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOM MD DLKING5WOOD If Under 24 Hrs. 8. Date of Birth (Month, Day, July 29, Birthplace (State or Foreign Country) unk 7. Age (In vrs. last birthday 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1⊠M 2□F 72 Director 123-40-4461 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State ir than "natural", or itams 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√2 No MD Montgomery Rockville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code 299 Hurley Avenue 20850 USA filed within 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. unk 1 ☐ Yes 2 ☐XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white lf Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed iink 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) iink 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) unk 1111 k 18 Mother's Name (First, Middle, Maiden Sumame) unk 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 is marked oth any light or other traumatic event size. Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 299 Hurley Avenue Rockville, MD Collingswood Nursing Home 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State `4 □Donation 5 \Other (Specify) in state 21. Signature Fune H Sonic Licensee Ronald S. Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARDIOPULMONARY Immediate Cause (Final ARREST **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PNEUMONIA S - uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to to, as a consequence of Examine been signed by the attending physician and should be detached for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Dav Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 DEMENT/A 1 Yes 2 No 3 Probably 4 Unknown Completed peen: DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an rector, page 2 s autopsy performed? Yes 2 No HYPERTENSION 1 🗆 Yes 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 Aursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After 1 Natural 5 Pending after death. 1 Tes 2 🗌 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Hospital 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cediffe 29d. Date signed (Month, Day, Year) 29c. License number 05/25/2005 D0061959 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20902 SILVERSPRING MD 1299 AMAN SIBAL. LAMBERTON DR

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUN 03 2005

32. Registrar's Signature

		i icasc			enartment of b		nd Mental Hy	giene						
	4	For State Registrer	State Registrar Certificate of Death Reg. No. 100											
		Decedent's Name (First, Middle, Last	51)			1.	2. Date of Dea	ath	3. Time of Death					
Physicia /Medic		Damon'te	Craiq	Tav	on Sp	ells	Month	26 2005	5 16 137PM					
Examin		4a. Fecility Name (If not institution, give	street and number)	. 1,	4b. City, Town, o	$\Omega$ $\Pi$	A	4c. County of Dee	eth					
		University of	Marylande	ledical	Center	Balt.	more	MA						
Funeral		5. Social Security Number 6. S	OM 2 F	(In yrs. last birt	rs Months Days		Min. (Month, Da	1	nthplace (State or Foreign ountry)					
Director	-	216-71-9560 Z	<u> </u>		4 22	J	1-4-	05	Md.					
ylanc how		10a, State 10b. County		10c. City, Town					10d. Inside City Limits					
e Ma	cto	Md. NA		B	altimore				1X Yes 2 No					
is 5, Indi yidnid Z IZ IO-000 s 1 and 2 should be filed within 72 hours after death with the Maryland the and Amenia Hygiene. Item Z7 is marked other then "naturel", or items 23s or 28s-f show other traumatic event, the Medical Evaninar must be notified at	Funeral Director	10e. Street and Number 1834 N. Rutland	Λυο		10f. Zip Code	.213		10g. Citizen of What C						
eath v	eral	11. Marital Status	12. Was Decedent Ev	ver in U.S.			n? (Specify Yes or No							
fter de	Ē	1 □XNever Married 2 □ Married	Armed Forces?  1  Yes 2 No		13. Was Decedent of H If Yes, specify Cub		Puerto Rican, etc.)							
ours a	þ	3 Widowed 4 Divorced	If Yes, Give △ Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	Specify: Black					
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d be entai	To Be	Damon		Spells	5	Lati	.a	Watki	ns					
id yid iid Kilon Kalan K	-	19a. Informant's Name/Relationship (	Type, Print)		Mailing Address (Street									
and 2 and 2 ealth a n 27 is		Latia Watkins	Mother	]	.834 N. Rut]	land Av			21213					
of He roth		20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from State	20b. Place of cemeter	Disposition (Name of y, crematory or other pla	ce)	Date	20c. Location - City of	r Town, State					
mit. Pages partment of lortant: If its		`4 ☐ Donation 5 ☐ Other (Specif	y)	Gre	eenmount Cen		6-3-05	Baltimor						
Defititions, we permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tre once.		21. Signature of Funeral Service Licer	1599		22. Name and Addre			timore, Md E. North A						
40244		23a Part 1 Enter the disease or com	nlications that caused t	he death. Do r	March F.I				Approximate					
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e be executed sician and burial-transit		resulting in death) Last	Due to (or as a	consequence	of):									
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OX OO /	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o					23d. Date of de	elivery					
ords, F.O. DC requires that the death een signed by the atter hould be detached for u	clar	in the past 12 months?	1□Live birth 2 4□Pregnant at ti		3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	;y		Month	Day Year					
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gned be de	ру Р	Part II. Other significant conditions of		1 -	( :1	ven in Part I.		obacco use contribute						
w requires been sign should be	ted	TACIERL	, com	piex	Congenita	21	_ 10	7	Probably 4 Unknown					
e 2 st	Completed	Heart Disease	e, Chronic	- Lun	1 Disease	<u>-</u> J	24a. Was		autopsy findings available completion of cause of					
VII.al Medicion: The lavicerificate has rector, page 2		Pulmonary H	ypertens	100			12 Yes	2 No 1 ☐ Ye						
	o Be	25. Was case referred to medical examiner?	Hospital:	t 2 ER/Ou	tpatient 3 DOA Ot	har	of Death (Check only o	one) dence 6 □Other (Sp	anti)					
OPhys Phys or this oral di	-	27. Manner of Death	28a. Date of Injury	28b. 1	Time of 28c. Inju	ıry at		how injury occurred	<del>o</del> chy)					
OVISION Tor Attending after death. Director: Afte	Certification:	Natural 5 Pending 2 Accident investigation	(Month, Day	1621)		ork? ]Yes 2.∐N	0							
	tific	3 Suicide 6 Could not be determined		y - At home, fa (Specify)	rm, street, factory, office		28f. Location ( City or To	Street and Number or F wn, State)	Rural Route Number,					
ital or irs afte ral Dire														
DIVISION OI • Hospital or Attending Phys 24 hours alter death. • Funeral Director: After this etely filled in by the funeral di	Medical	29a. Certifier (Check only one)  1 Certifying Pl 2 Medical Exam	nysician: To the best of miner: On the basis of and manner stat	examination an	e, death occurred at the t d/or investigation, in my	me, date and opinion, death	place, and due to the occurred at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)					
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature of the cause of death occurred at the time, date and place, and due to the cause of death occurred at the time, date and place, and due to the cause of death occurred at the time, date and place, and due to the cause of death occurred at the time, date and place, and due to the cause of death occurred at the time, date and place, and due to the cause of death occurred at the time, date and place, and due to the cause of death occurred at the time, date and place, and due to the cause of death occurred at the time, date and place, and due to the cause of death occurred at the time, date and place, and due to the cause of death occurred at the time, date and place, and due to the cause of death occurred at the time, date and place, and due to the cause of death occurred at the time, date and place, and due to the cause of death occurred at the time, date and place, and due to the cause of death occurred at the time, date and place, and due to the cause of death occurred at the time, date and place, and due to the cause of death occurred at the time, date and place, and due to the cause of death occurred at the time, date and place, and due to the cause of death occurred at the time, date and place, and due to the cause of death occurred at the time, date and place, and due to the cause of death occurred at the time, date and place, and due to the cause of death occurred at the time, date and place, and due to the cause of death occurred at the time, date and place, and due to the cause of death occurred at the time, date and place, and due to the cause of death occurred at the time, date and place, and due to the cause of death occurred at the time, date and place, and due to the cause of death occurred at the														
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Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	Anast 3			,	•					
Registi	ar	JUN 0 3 2	005 Moles	a st	STORES									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) May 31, **Physician** 2005 Рм 2:10 Helen Sellers /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Dundalk Heritage Nursing Home 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 25F 73 April 3,1932 Maryland Director 212-28-9631 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Baltimore Essex 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number ö 238 U.S.A. 21221 1723 Eastern Boulevard death 1 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. , or Items filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: þ White 3 XWidowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Importent: If item 27 is marked other then any injury or other treumetic avant. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home Unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mamie McLumas John Jacob Frey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 29 Trumpeter Way, New Oxford, Pennsylvania 17350 Robert J. Sellers, Jr. (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard. June 3,2005 Baltimore, Maryland <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Servee Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Aspiration Pneumonia /Medical Due to (or as a consequence of): **Examiner** <u>Seizure Disorder</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the burial-transit Dementia and Due to (or as a consequence of): Box 68760. the attending physician Congestive Heart Failure Physician/Medicai use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 200No be detached Records, P.O. 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 ∭Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page 2 certificate 2 X No 1 Yes Division of Vital or Attending Physiclen: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes P 2 XNo 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 Pending Injury 1 XNatural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident **Director**: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funerel I

completely filled To the Hospitel t 💢 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D27188 USE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 Market Place, Dundalk, Maryland 21222 Savinder Julka, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005

DHMH 17 Rev 1/2001

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear SEAL 2:304 2000 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 119287 BA-L+1 3014 OURS 0 MO If Under 1 Year | If Under 24 Hrs. 8. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number Hours 1□ M 2 F Months Days 32-823 Usual Residence of Decedent 10h County 10c. Çity, Town or Location 10d. Inside City Limits 10a, State 1 Yes 2 □ No ALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number .5.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify; 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Poute Number, City or Town, State, Zip Code) 9a. Informant's Name/Relationship (Type, Print) 4LD 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 Other (Specify) 22. Name and Address of Facility Signatu Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 Caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Part1. Enter the disease, or shock, or heart failure. complications the Immediate Cause (Final CEMIA disease or condition resulting in death) Due to (or as a consequence of): CARDIOVASCULAR DISEASE ENSIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): MELLITUS ABE Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Føtal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Onknown 24a. Was an

**Physician** /Medical **Examiner** 

the attending physician and

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28a-f show

Director

Completed by Funeral

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77 is marked other than "naturel", or items 23s or 28s-f shov traumatic event, the Medical Examinar must be notified at

with the Maryland

filed within 72 hours after

Hygiene.

permit. Pages 1 and 2 should be fille. Department of Health and Mental Hydr. Important: If item 2.7 is marked any injury or other 3.7 is marke

Baltimore, Maryland 21215-0036

use as the burial-transit ğ detached After this certificate has been signed by interest director, page 2 should be detact filled in by the

The law requires that the death certificate be executed

Hospital or Attending Physiclan:

death.

Director:

within 24 hours a To the Funeral C

completely

Division of Vital Records, P.O. Box 68760

Examiner

Physician/Medical

Be Completed

Certification: To

Medical

autopsy 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2□ No

> 25 VS

25. Was case referred to medical examiner? 2 No 1 🗌 Yes 27. Manner of Beath

Hospital: 28a. Date of Injury (Month, Day Year) 5 Pending investigation

1 Inpatient

and manner stated.

2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Dther: 28c. Injury at Work? 2 □ No 1 Yes

4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 Accident

3 Suicide

4 Homicide

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

SECOURS

29b. Signature and title of certifier 6

6 Could not be

29c. License number 0030355

ON

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CR42 M-

State Registrar JUN 0



			For State Registrar	State of Ma	arylan		artmen rtificate				ental H	ygiene Reg. No	2005	18673		
	Physici	an	1. Decedent's Name (First, Middle, La Elsie Stanton	ist)							2. Date of E	eath	2005 Year	3. Time of Death		
	/Media		4a. Facility Name (If not institution, give	ve etreet and number			4h Cihi	Town or	Location o		May	_	County of Dea	4:20 A M		
	Examir	ıer	68 1/2 Madison St				Westm			Death		Carrol1				
	Funeral				e (In yrs.	last birthday)	If Under	1 Year	If Under 2		8. Date of B (Month, L			thplace (State or Foreign		
	Director		217-38-4811 Usual Residence of Decedent	1□М 2ДТ	68	Yrs.	Months	Days	Hours	Min.	Oec. 2	24, Year,	936 Ma	ountry) ryland		
	ırylan Ihow	_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits		
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920	within 72 hours after death with the Maryland nne. then "netural", or Items 23e or 28e-1 ahow a Mudical Ever in at rival be notified a	by Funeral Director						Decedent of Hispanic Origin? (Specify Yes or Nos., specify Cuban, Mexican, Puerto Rican, etc.)  Yes 2 No Specify:					14. Race - Ame Black, White Specify: Wh			
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Maryland 21215-0036	ould be filed Mental Hygie arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last) Freeman Thompson  Lil								First, Middl Fog1e	e, Maider	Sumame)			
ary	s 1 and 2 should f Health and Men item 27 Is marke other treumatic		19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	g Address	(Street a	ind Numbe	r or Rurai	Route Num	ber, City	or Town, State,	Zip Code)		
≥,	1 and Health iem 27 other tr	17	Fay Fields	Sister		_			Road		Airy,		21771			
Baltimore,	ges 1 t of H If itel		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	C	lace of Dispo emetery, cren	natory or ot	her place		Da [une_:		20c. Le	ocation - City or	Town, State		
Ε̈́Ε	t. Partmen rtant:		4 ☐ Donation 5 ☐ Other (Special		Tay	lorsvi	TIE C	MC emet	ery	2005	,	Tay1	orsvill	e, MD		
Ba	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature Funeral Service Lights 22. Name and Address of Facility Burrier-Queen Funeral Home & Cre 1212 W. Old Liberty Road Winfie										Cremato field,	ry, PiA MD, 21784		
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Вох	death certificate be executed e attending physician and id for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pre	gnancy				ļ	23d. Date of del	,		
	the at	/sici	in the past 12 months? 1 □ Yes 2 SNo 9 □ Unknown	4☐ Pregnant at 9☐ Unknown			Other (spe	ecify)					Month	Day Year		
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ita	ysiclan: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?						26. Place	of Death	Check only					
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	1		1 June 1	Herse	0	ms		50	166	5		05	5/31/0	5		
	\0		30. Name and address of person who	completed cause of de	eath (Item	1	Print)	44	n E	PST	mi	3/N	ST.			
	۳		VINCENT J	Flores	-J.		V	VES					·) =	1157		
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			For	State of Maryland	/ Depa	rtment of H	lealth and Me	ntal Hygier	ne	
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	/Medic	al	Wille	James	SC	> T /		ray 29	2005	2.10 PM
4	Examin	er	4a Facility Name (If not institution, give		Green	46. City, Town, o	r Location of Death	10	c. County of Death	
	Funeral		5. Social Security Number 6. Se	1		If Under 1 Year	If Under 24 Hrs. 8	. Date of Birth	9. Birtho	lace (State or Foreign
	Director		216-32-8275 1	M 2□ F	Yrs.	Months Days	Hours Min.	(Month, Day, Yea	937nor	The Carolina
	and **		Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Loc	ation			1	0d. Inside City Limits
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	ems 23	ner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	5. 13. W	/as Decedent of H Yes, specify Cuba	lispanic Origin? (Speci an, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Americ Black, White,	
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5-0036	ž 5		15. Decedent's Edi		16a. Decede	ent's Usual Occup	pation	16b.	Kind of Business/Inc	dustry
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and	be filk	Be	17. Father's Name (First, Middle, Last)	Sant	4		18. Mother's Name (	First, Middle, Maid	en Sumame)	0
Maryland	should be nd Menta marked matic ev	으	19a. Informant's Name/Rel 12 nship (T	ivne Print)	19b Mailing	Address (Street	and Number or Rural F	Route Number, City	or Town State Zin	Code)
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Baltimore	permit. Page Department of Importent: If eny injury or once.		21. Signature of Funeral Service Licen	See /	22.	Name and Addre	ss If Facility Fra	uklin	St.	
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			23a. Part1. Enter the disease, or comp shock, or heart fail i.e. List only of Immediate Cause (Fin	ine cause in each line.	A	r the mode or dylin	ig, such as cardiac or r	espiratory arrest,		Approximate Interval Between Onset and Death
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Box	requires that the death certifics een signed by the attending pt hould be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan 1□Live birth 2□Fetal o		Ectopic pregnancy			23d. Date of delive	ery
_	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of dea		Other (specify)	,		Month	Day Year
P.O.	res that the de signed by the a I be detached t	Phy	9 Unknown  Part II. Other significant conditions co		ting is the	dorbina aguas an	on in Day!	22e Did tobaco	use contribute to the	an cause of death?
ds,	ires the signed dibe of	1 by	CV. LOUICE	Les of Car	0 1	CIO (	en in Faiti.	10		ably 4 □Unknown
Records,	- Q 70	iete	Colorect	0000	200	, cont	7	24a. Was an	24h Were auto	psy findings available
	e la has le 2	Completed					<b>∀</b>	autopsy performed?	prior to cor death?	npletion of cause of
ital	ician: Th certificate rector, pag	a)	25. Was case referred to medical			- 12.	26. Place of Death (	1  Yes 202N Check only one)	to I T tes	200
) į	\$ S	To B	examiner? 1 □ Yes 2 No		R/Outpatient	3□ DOA Oth	er: 4 Nursing Home	5 Residence	6 ☐Other (Specif)	1)
n o	ding Pl		27. Manner of Death  1. ■ Vatural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Wor		d. Describe how in	jury occurred	
Division of Vital	Attending Physician: ar death. ector: After this certific by the funeral director,	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hon	ne farm stre		Yes 2 No	f. Location (Street	and Number or Rura	I Route Number
Σ	after Direct	Certification:	4 Homicide determined	building, etc. (Specify)	10, 141111, 3116	ot, factory, office		City or Town, Sta	ite)	Troute rumber,
	Hospitel 4 hours a Funerel t lety filled		29a. Certifier  (Check only  (Check only  (Check only  (Check only)	rsician: To the best of my know iner: On the basis of examination	rledge, death	occurred at the tin	ne, date and place, and	d due to the cause	(s) and manner as st	ated.
	the the	Medical	one)	and manner stated.						
	With To	4	29b. Signature and title of certifier	o Reold		29c. Licens		290. [	Date signed (Month,	005
	$\cap$		30. Name and address of person who s	ampleted cause of death /lear	23a) (Tuna B	Print)	1411	300		
			82 Name and address of person with	5w Sheet	Scu	F312	Boll	inoro 1	4D21	201
	Sta		31. Date filed (Month, Day, Year)	32. Paistrar's Signatu	ıre				· ·	
	Registi	ar	JUN 0 3 2	2005 Server	J 19	642				

		-	For State Registrar	State of Man		artment of H tificate of L			ene g. Ng 0 0 5	18676		
			Decedent's Name (First, Middle, La.	st)				2. Date of Death		3. Time of Death		
	Physicia /Medic	al	John Jenni		imetz			May 27	T	5:45 p <sup>M</sup>		
	Examin	er	4a. Facility Name (If not institution, giv 5100 Whiteford F			4b. City, Town, or Baltin	Location of Death		4c. County of Death			
	Funeral		5. Social Security Number 6. S	ex 7. Age (1	In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign		
Ш	Director		485-16-5277	<b>X</b> M 2□ F	86 Yrs.	Months Days	Hours Min.	April 16	, 1919	Iowa Iowa		
	pug *		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or Lo	cation				10d. Inside City Limits		
	Manyik f sho	lor	MD n/a		Baltin	nore			1 ∑Yes 2 □ No			
	r 28a	irec	10e. Street and Number		-	10f. Zip Code		10g. Citizen of What Country?				
	23a c	raiD	5100 Whiteford			21212			U.S.A.			
	ours after death with the Marylan rai' or Itams 23a or 28a-f show Evanting must be inclitted at	Funeral Director	11. Marital Status	12. Was Decedent Eve Armed Forces?		Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi			
36	urs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates:	WW II	1□Yes 2√√ No	Specify:		Specify: U	Uhite		
21215-0036	within 72 hours after death with the Maryland one. Than "natural", or flams 23s or 28s-f show he Medical Evanting Frust Le Indilliad at	ted	15. Decedent's E (Specify only highest gra	ducation	16a. Dece	dent's Usual Occupa	ation during most of works	16b. Kind of Business	/Industry			
21	within one one.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		po not use retired cems Analy	•		State of M	Maryl and		
N	thar nt,		17. Father's Name (First, Middle, Last		byst	CINO TITALS	18. Mother's Name			101 y 10110		
au	should be fand Mental Band Mental Band Mental Bandwed o's marked o'umatic ava	To Be	John N.	Steimetz			Sabin	а	Jenni	ings		
Maryland	s 1 and 2 should f Health and Mer itam 27 Is marke other traumatic		19a. Informant's Name/Relationship (	**		City or Town, State,	Zip Code)					
	1 and 2 Health tam 27 other tr		William Steimetz	imore, M	D 21234 20c. Location - City of	Town State						
Jore	Pages 1 nent of H int: If ita	- m	20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Speci		20b. Place of Disponsion Commetery, cremetery, cremetery.	natory or other plac			Tawson, MD	,		
Baltimore,	- F 25 - F		21. Signature of Funeral Service Lice	-	. Dau 22	2. Name and Addres	ss of Facility Run	k Tausan I	Funeral Home	. Inc.		
ñ	Deparenti Deparenti Impon any ir		MM		1	050 Yark Ro	l., Towson,	MD 21204				
г			23a. Part1. Enter the disease, or com shock, or heart failure. List only	polications that caused the one cause on each line.	ne death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Doubth		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Myoc	WINA	Intav	OWN			nowic		
	Examiner			Que to lor as a	consequence of):	Carlo	2 my 8 f	athy		Cham?		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	consequence of):			1				
	be executed ician and burial-transit	cami	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to for as a	consequence of):							
8760,	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	dical Examiner		Due to (or as a c	sorisaquarica ory.							
687	fficate g phys as fhe	edic		.200								
Box	ih cert endine r use a	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth 2	pregnancy	Ectopic pregnancy	,		23d. Date of de Month	blivery Day Year		
	that the death certific ed by the attending p detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at tir 9□Unknown	me of death 5	Other (specify)			19101111	buy low		
P.0	fhat fh ed by detacl	/ Ph)	Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tot	pacco use contribute t	to the cause of death?		
rds,	quires fhat n signed t uld be det	d by						1 □ Ye	es 2 <mark>⊡ N</mark> o 3 □ P	robably 4 Unknown		
Records,	s b	Completed						24a. Was a	n 24b. Were a	utopsy findings available completion of cause of		
R	The afe h page	Com						perform 1 Tes 2	ned? death? 2			
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Cth	26. Place of Deat			· · ·		
of		7: To	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date of Injury (Month, Day)					ence 6 Other (Spanish on the control of the control	өспу)		
ion	Attanding Phyrdeath. sector: After thi	atior	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	K? Yes 2 □No								
Division	ter de irecto	Certification:	3 Suicide 6 Could not determined	28e. Place of Injury building, etc.	y - At home, farm, st (Specify)	reet, factory, office		28f. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,		
	pitat c		29a, Certifier 1 Certifying P	hysician: To the best of	my knowledge deat	h occurred at the tir	me date and place	and due to the c	ause(s) and manner a	s stated.		
	To the Hospital or Attandir within 24 hours after death. To tha Funeral Director: Al completely filled in by the fu	Medicai	(Check only 2 Medical Exa	miner: On the basis of e and manner state	xamination and/or in	ivestigation, in my o	pinion, death occur	red at the time, d	ate and place, and du	e to the cause(s)		
	To th withir To th comp	Me	29b. Sign ture and title of certifier	Calin	No.	29c. Licens	e number	2	9d. Date signed (Mor	th, Day, Year)		
	Ì,		ywia	3000	W~ /	2 2	レフリン		701/	200)		
P	04/1	1	20. Name and address of person who	completed cause of dea	ath (Item 23a) (Type,	sch la	ven Blu	d Ba	th min	6 MD 21230		
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	B w						
	Regist	rar	181937 ()	n 2805 1/2	12	March 9						

			. icas		ryland / Dep							Jibic.		
			1 - For State Registrar	State Of IVId		e <i>rtificate</i>					Reg. No.	05	186	77
			Decedent's Name (First, Middle, )	Last)						2. Date of Dea	ıth	Varia	3. Time of	Death
	Physici /Medic		Carol Ann	Shenton						May 22	2 Day 2	005	5:00	P M
*	Examin		4a. Facility Name (If not institution, g	give street and number)		4b. City,	Town, or	Location	of Death		n			
			Chesapeake 1					ridg If Under	e 24 Hrs	9 Date of Birth		ester	r Foreign	
	Funeral Director		5. Social Security Number 217-42-5744	1 M 2 F 7. Age	(In yrs. last birthday 59 Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Nov 10,	1945	Mary	nplace (State o untry) y Land	or i-oreign
	TO		Usual Residence of Decedent											
	arylar show	_	10a. State 10b. County		10c. City, Town or I								10d. Inside C 1 ☐ Yes	
	the M	ectc	MD Dorche	ster	Camb	ridge 10f. Zip	Codo				10g. Citizen	of What Co		-X-
	with 3a or	١٥	2967 South Roa	d		101. 210		613			US US	untry:		
	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Itema 23a or 28a-f show other than "natural", or Itema 23a or 28a-f show event, the Medical Evantiral rulal be rediffied at	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13	. Was Deced	lent of Hi	ispanic Or	igin? (Spe	ecify Yes or No- Rican, etc.)	14. F		ncan Indian,	
9	or Ite	y Fu	1 ☐ Never Married 2 ☐ Married	1 □Yes 2 N If Yes, Give		1 🗆 Yes 🔞		Specify:		riicari, etc./	Spe	lack, White c <i>ifv:</i> τσ	hite	
Ö	hours tural',	ed by	3 ☐ Widowed 4 ② Divorced  15. Decedent's	Year or Dates:	162 Doc	edent's Usua					16b. Kind of			
ry ry	in 72	Completed	(Specify only highest	grade completed)	(Giv	e kind of woi DO NOT us	rk done d se retired	during mos ()	at of worki	ing	TOD. KING O	Dusiness/i	noustry	unk
212	d with giene. or than	omi	Elementary/Secondary (0-12)	College (1-4or 5-		usekee	per							
2	al Hy d othe	Bec	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)									ame)		
yla	ould b Ment warked	2	Albert Harold							a Elizal				
Maryland 21215-0036	12 sh h and 7 Is rr traur	0 1	19a. Informant's Name/Relationship Lisa Robinson/							A Route Numbe	r, City or Tov 21626	vn, State, Z	ip Code)	
	Healt Healt tem 2		20a. Method of Disposition		20b. Place of Disp	89 Robbins Road Crapo Disposition (Name of paratory or other place)			Date		Oc. Location - City or Town, Stat			
OE.	Pages ent of nt: If i		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		cemetery, cr	ematory or o	ther plac	θ)						
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		21. Sig attra of Funeral Service Lice Lice Nonald S		zror _ S	22. Name an	d Addres	ss of Facili	ty oard	655 W.	Balti	more	Street	
	E0780		222 Part Enter the disease of or	A Color that caused	B	altimo	re,	MD	2120	1			Approximat	io.
Н			23a. Part 1 Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final	nly one cause on each lin	_		e or dynn	g, sucii as	cardiac	n respiratory an	1631,		Interval Bet Onset and	tween Death
	Physician /Medical		disease or condition resulting in death)	a. <u>renal</u>	failu consequence of):	re							6 mo	ntas
	Examiner				epsis								1 moi	nth
	D #	ner	Secue tially list our ellion if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	co sequence of):					,			211	
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	consequence of):	9 e.	SOL	na	917	75		-	200	eks	
760,	icate be executed physician and s the burial-transit	caiE		d. <u>CO/</u> (								þ	1 moi 2 we 2 we	ekr
687				a	// 3									
Вох	leath certificat attending phy I for use as th	M/u	IF FEMALE: 23b. Was decedent pregnant	☐Ectopic pregnancy						Date of deli	•			
B	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							Month	Day Year		
P.O.	that the de ned by the a detached f	Phy	9 ☐ Unknown 9 ☐ Oriniown 9 ☐ O								bacco use co	ontribute to	the cause of o	death?
ds,	signe d be d	d by	Tutti, other eigninean container.	o continuous g to dodar bu	thot roouting in the	andonying or	auso give	JII III I WILL			es 2 DMo		bably 4 🗆	
COL	w requir been si should	Completed								24a. Was a	an 24	o. Were au	topsy findings	available
Vital Records,	i <b>lcian:</b> The lav certificate has rector, page 2	ошь		****						autop perfor	sy med? 2 1 No	death?	ompletion of c	cause of
ţa		Bec	25. Was case referred to medical examiner?					26. Place	e of Death	(Check only or		, , , , , ,		
of V	Physician: r this certific ral director,	၉	1 ☐ Yes 2 ☐ Ho	Hospital: 1 ☐ Inpatier			100.00	462140		me 5 Resid			cify)	
NC On C	ding Physician: n. After this certific funeral director,	ion:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigal	28a. Date of Injur (Month, Day	Year) 28b. Time Injury		8c. Injury Work			28d. Describe h	ow injury occ	urred		
Division	Attender deatl	fica	3 Suicide 6 Could no	t be 28e. Place of Inju	ry - At home, farm, s					28f. Location (S		mber or Ru	ral Route Nun	nber,
<u>S</u>	s after s after al Dire	Certification;	4  Homicide	building, etc	(Specify)					City or Tow	n, State)			
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical (	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of taminer: On the basis of and manner sta	examination and/or	ath occurred investigation,	at the tim in my op	ne, date ar pinion, dea	nd place, ath occurr	and due to the d ed at the time, d	ause(s) and date and plac	manner as e, and due	stated. to the cause(s	s)
	o the	Med	29b. Signature and title of certifier			290	. License	a number		- 4	29d. Date sig	ned (Month	n, Day, Year)	
)	- > - 0		> Ofaar	edn do		/	400	59	97:	3	5/20	105	2	
			30 Name and address of person wh	no completed cause of de	ath (Item 23a) (Type Dramb	e, Print)	/	7 = 10=	hri	toe M	0 0	110 1	3	
	Sta	ite	31. Date filed (Month, Day, Year)	pz. negistra	i s olgnature		Ç	CVN	0110	40,	J 80,	4/		
	Registr		JUN 0 3 200	5 Marie	It Spe	A D								

State of Maryland / Department of Health and Mental Hygien 2 0 5 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Yeer TOLAND 1830 P M TUNE JOH N 2005 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner NORTHWEST HUSPITAL RANDALLSTOWN BALTIMORE Under 1 Year | If Under 24 Hrs. | 8. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Dey, Yea 4-16-4 9. Birthplece (State or Foreign Country) **Funeral** Days Hours Min 1 M 2□ F 215-52-0332 Yrs. Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Baltimore 1 Yes 2 □ No Director WD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5406 enue 21215 AZU Completed by Funeral death Was Decedent Ever in U.S. Armed Forces?

1 Yes 27 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working Me. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 1.2 should be filed within 72 h and Mental Hygiene. 7 is merked other than "na Elementary/Secondary (0-12) College (1-4or 5+) pervison permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If tem 27 is marked other event eny injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame lola 19a. Informant's Name/Relationship, 19b. Mailing Address (Street and Number or Rur I Route Number, -06 20b. Place of Disposition (Name of cemetery, crematery or other p 20a. Method of Disposition 1 Burial 2 Cremation 3 R 3 □Removal from State Signature of Fuperal Service License Services Vaugh 100 21133 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, codeant failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause End Unoutying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Box 68760. attending physicien Physician/Medical the use as i IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 🐼 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No autopsy performed? 2 No the Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide hours after within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0056369 June 2 2005 person who completed cause of death (Item 23a) (Type, Print) Northwest Hospital 5401 Old Court Road Randallstown, HD Deborah Belchis HD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene [1] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** June 2, 2005 Jeanette E. Taylor 10:30 a<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town or Location of Death Examiner Harford 1306 Clary Court Belcamp If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 □ F Yrs. Director 83 3, 1921 220-07-1285 Maryland Usuel Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10h County 10d, Inside City Limits 7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Medical Examinar must be notified at Md. Harford Belcamp 1 ☐Yes 2€ No Director 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? U.S.A. 1306 Clary Court 21017 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or item 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white þ 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 years homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John S. Bohle Margaret Wilhem 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains000. 1306 Clary Court, Belcamp, Md. 21017 Mrs. Pat Shaffer/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 6/4/2005 Oak Lawn Cemetery Baltimore, Md. \* 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licensee 610 W. MacPhail Road, Bel Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Congestive heart tailure disease or condition resulting in death) 5 years /Medical Due to (or as a consequence of): Examiner Lardiomyopathi YEARS Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dua to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed ar 20 48 Grs Coronard resulting in death) Last Due to (or as a consequence of) 68760 Physician/Medicai Box ( IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a Wasan certificate has autopsy performe 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 sidence 6 Other (Specify) 1 ☐ Yes 2 No ပ this funeral 27, Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after within 24 hours a To the Funeral D 29a. Certifier McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai completely (Check only one) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Muhael Norman Drossner MD D 32288 June 02, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Norman Drossner, 520 Upper Chesapeake Drive, Suite 201, Bel Air, Mary land 21014 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/200

Registrar

JUN 03 2005

State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2005 11:05 A **Physician** 10 Mollie Lee VanSkiver /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner mie Anna runde 15 VIRITE VW If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Pay 2/22/19 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number **Funeral** Days Min Baltimore, Months Hours 1 □ M 2 □ F 215-28-6573 73 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 X No Completed by Funeral Director Pasadena Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21122 USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. If flam 27 is marked other than "natural", or items 23a any injury or other traumatic evant, the Medical Ferre 414 Quiet Woods Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Motor Vehicle Admin. 10 Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Moore Roland Gregory Agnes 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 414 Quiet Woods Court, Pasadona, MD 21122 <u>George Van Skiver</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/2/2005 Metro Crematory Baltimore, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Rd Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. Approximate Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for es a consequence off Examine physicien and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the o 9 Unknown à ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attanding 5 Pending investigation 1- Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To tha Funeral Diractor: A 2 Accident 6 Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) egistrar's Signature 31. Date filed (Month, Day, Year, State Registrar

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Mollice

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death JUNE 1, Year **Physician** 2005 11:08 A M VILNER MARK /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE BALTIMORE 6968 MARSUE DRIVE APT. #1-C 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. And Months Days Hours Min. A (Months Day ) 4 Co. 1 5. Social Security Number 6. Sax 9. Birthplace (State or Foreign **Funeral** 1₹M 2□F UKRAINE 218-57-3431 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or items 23s or 28e-f sho The Medical Examinar must be notilized at 1 ☐ Yes 2 🕅 No BALTIMORE BALTIMORE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UKRAINE 6968 MARSUE DRIVE APT. #1-C 21215 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🗖 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married WHITE 1 Yes 2 No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygienn Important: If item 27 is marked other the any injury or other traumatic event. The 2005 NURSE NURSING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be (UNKNOWN) VILNER MIRIAM MIKHAIL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MD 21215 APT. #1-C ERINA SHKOLNIKOVA / WIFE 6968 MARSUE DRIVE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ARLINGTON CHIZUK AMUNO 6/2/2005 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Lie 22. Name and Address of Facility SOL LEVINSON & BROS. INC. ńsee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Pa 11. Enter the disease, or complication of shock, or heart failure. List only one call of t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) nevosclevotic Cardiovascular Dras **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examiner Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Certification; To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death 1 [2]Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

attending physician and

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certificate

After

after death

within 24 hours a To the Funeral I

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person who completed cause of death (Item 23a) (Type, Print)

M() 2005 32. Redistrar's Signature

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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 2**X** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6  $\bar{\mathbf{X}}$  Other (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 □ No 3 🗌 Suicide 6 □ Could not be

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

the Hospital or Attending Physician: a Funeral i within 2

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

2300 DULANEY VALLEY RD. DR. TARIQ MAHMOOD TIMONIUM, MD 21093

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4 Homicide

29a. Certifier (Check only one)

JUN 0 3 2005

determined



Registrar

		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Beg. No.  Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State Beg. No.  Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State Of Maryland / Department of Health and Mental Hygiene
Physio /Med Exami	ical	1. Decedent's Name (First, Middle, Last)  Dolores Cecelia Wilfer  4a. Facility Name (If not institution, give street and number)  Manor Care Nursing Home – Rossville  Certificate of Death Month June 3, 2005 1:32 AM Manor Care Nursing Home – Rossville  Reg. No.  2. Date of Death June 3, 2005 1:32 AM Manor Care Nursing Home – Rossville  4b. City, Town, or Location of Death Baltimore
Funeral Director		5. Social Security Number 214-24-7124  G. Sex 7. Age (In yrs. last birthday) To Age (In yrs.
h the Maryland or 28e-f show	Director	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits  Maryland Baltimore Essex 1 □ Yes 2 ☒ No  10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
If e, INIAL yiallia ZIZIS-0030  I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene item 27 is marked other than "natural", or frams 23a or 28e-f show other traumetic event, the Madical Exacting market natified at	by Funeral	15.01 Cherry Garden Road  11. Marital Status  1    Never Married 2
d Z I Z I 3-0 filed within 72 ho Hygiene. kther than *natur ant, ine Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 10  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Manager  16b. Kind of Business/Industry  16b. Kind of Business/Industry  Fast Food
Marytand Is should be file and Mental Hy Is marked othe reumetic event,	To Be C	17. Father's Name (First, Middle, Last)  Joseph LaFortezza  18. Mother's Name (First, Middle, Maiden Sumame)  Mary Ann Calvano  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
t. Page rtment or rtent: If		James Nicholas Wilfer (Son)  11 Mainsail Court, Middle River, Maryland 21220  20a. Method of Disposition  **Theurial 2 Cremation 3 Removal from State  **4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Sacred Heart of Jesus  21. Signalure of Fineral Service (Canser)  22. Name and Address of FacilityBruzdzinski Funeral Home, P.A.
Dermi Depa Impo		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death disease or condition in death)  Approximate Interval Between Onset and Death Onset and D
Medical ate be executed ate be executed avsician and he burial-transit	ai Examiner	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Errier underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):
The law requires that the death certificate the has been signed by the attending physage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
law requires that as been signed b 2 should be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 These 2 No 3 Probably 4 Unknown
	Completed	24a. Was an autopsy performed?  1 □ Yes 2 No 1 □ Yes 2 No
To the Hospital or Attending Physician: 1 within 24 hours after death. To the Funaral Director: After this certificat completely filled in by the funeral director, p	ertification; To Be	25. Was case referred to medical examiner?    Yes   2X   No
he Hospital in 24 hours i he Funaral pletely filled	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
To t To t	×	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
Si Regis	tate trar	31. Date filed (Month, Day, Year)  JUN 0 3 2005  Solution of death (Item 23a) (Type, Print)  Registrar's Signature  JUN 0 3 2005
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** WAGNER DONALD 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner NURSING EHAB RING MONTGOMER FAIRLAIND If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) MARYLAND 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Year) Days 1₩ 2□ F Yrs 218-52-808 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Pres 2 No Director PRINCE GEORGES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Itema 23a VERDAL STATES RD. APT death v NITED Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status ges 1 and 2 should be filed within 72 hours after it of Health and Mental Hygiene. If item 27 le marked other than "natural; or Ite 1 Yes 2 No If Yes, Give Year or Dates: 2 Married 1 Never Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: 人人 HITE ፩ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Spcondary (0-12) College (1-4or 5+) MAINTENANCE TECHNICIAN PROPERTY MANAGEMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) BENJAMIN WHGNER HNNA MAE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4702 RIVERDALE RD APTS RIVERDALE, MD 20137 SPOUSE BETTY WAGNER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. ö 5 Other (Specify) 7/05 HANOVER MI 4 Donayon ANATOMY GIFTS IZEG eral Service Lig 22. Name and Address of Facility

ALUSINERTY FAMILY FUNERAL HOME 2601 MOUNTAIN RO PASADONA, MOZILZZ 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Physician BRAIN TUMOR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the buriai-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate 1∐ Yes 2. No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 2 ER/Outpatient 3 DOA this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred Certification; After 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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DHMH 17 Rev 1/2001

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of Hortificate of L			ene	18685			
	Physici	an	1. Decedent's Name (First, Middle, Las	/	IACE.			2. Date of Death Month	Day Year	3. Time of Death			
	/Medic Examin		4a. Facility Name (If not institution, give		11908	4b. City, Town, or	Location of Death	05-2	4c. County of Death	27-30pm			
	LXaiiiii	ici	Universit 1 Mary land	Medial &	stowns	RALT	TMOR E	5					
	Funeral		5. Social Security Number 6. So	7. Ag	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth				
	Director		Usual Residence of Decedent	7	7/ Yrs.			09/05/19:	33   Mary	land			
	yland		10a. State 10b. County		10c. City, Town or Lo	ocation				0d, Inside City Limits			
	89-fs	ctor	Maryland		Ba1	timore				1⊠Yes 2 No			
	with th	Dire	10e. Street and Number 3115 Mayfair Road			10f. Zip Code 21207	7	10g	. Citizen of What Coul	ntry?			
	ms 23	eral	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of His	spanic Origin? (Spe	cify Yes or No-	U.S.A.	can Indian,			
9	after or Itan	by Funeral Director	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 X Yes 2 ☐ I If Yes, Give	No 1949	If Yes, specify Cubar  1 ☐ Yes 2 X No	i, Mexican, Puerto F Specify:	Rican, etc.)	Black, White, Specify: B1a	etc.			
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28e-f show tha Madical Examinat must be notified at	d b	3 XWidowed 4 □ Divorced  15. Decedent's Ed	Year or Dates:	1950	dent's Usual Occupa							
-51-2	n "nal	Completed	(Specify only highest gra	de completed)  College (1-4or s	(Give	kind of work done di DO NOT use retired)	uring most of working	ng 16	b. Kind of Business/In	austry			
212	ad with	Com	12	College (1-40)	U U	pholster		1	Upholstery				
pu	2 should be filed within and Mental Hygiene. is markad other than aumatic avant, the Me	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Ma	iden Sumame)				
Maryland	should and Men marka umatic	70	Pratt Wallace  19a. Informant's Name/Relationship (7)	voe Print)	19b Maili	no Address (Street a		Frazier	City or Town, State, Zip	Code			
_	t and 2 s Health ar em 27 is ithar trau		Laura Wheeler / Da	•					ore, Maryl				
Baltimore,	es 1 a of Hei fitem r otha		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Domoval from State	20b. Place of Dispo	osition (Name of matory or other place	Di		c. Location - City or To				
ij	Pages Iment of I Ient: If its jury or o		*4 ☐ Donation 5 ☐ Other (Specify	)	Woodlawn	Cemetery	05/31	/2005 W	oodlawn, M	ryland			
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28e-f show amy injury or other traumatic avant, the Madical Examinar must be notified at once.		21. Signature of Funeral Service Licen		2	2. Name and Address	s of Facility The	Derrick	C. Jones	F/H, P.A.			
			23a. Part1. Enter the disease, or comp	olications the caused	the death. Do not en				nore, Mary	Approximate			
U	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each II	to Bla	ed Strea	1 125	6	\	Interval Between Onset and Death			
	/Medical Examiner		resulting in death)  Duy to (or as a consequence of):										
	LAdminer	Je.	Sequentially list conditions	b. Due to (or as	a consequence of:	ente se	#- To	422	MEL				
7	uted d ansit	Examiner	Sequentially list nonditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	2									
00	s be executed sician and burial-transit	I Exa	resulting in death) Last	Due to (or as	a consequence of):								
8760	ate h	dical		d									
ox e	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of delive	erv			
Ω.	ne death the atte	Icla	In the past 12 months? 1 ☐ Yes 2 ☐ No	1∐Live birth 4∏Pregnant at 9☐Unknown		□Ectopic pregnancy □ Other (specify)			Month	Day Year			
P.0	that the do	Phys	9 Unknown					One Did tohan					
ds,	uires tha signed id be del	d by	Part II. Other significant conditions of	ontributing to death b	out not resulting in the u	inderlying cause give	n in Part I.	1 Tes	co use contribute to th				
Records,	w requir s been s should	Completed				-		24a. Was an	24b. Were auto	psy findings available			
Re	The lav	фщо						autopsy performe	<ul> <li>prior to cor</li> </ul>	npletion of cause of			
Vital		Be C	25. Was case referred to medical examiner?				26. Place of Death		110 12100				
of V	59	2	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatie	-		4   Nursing Hon		e 6 Other (Specify	/)			
OU		tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	y Year) 28b. Time o	Work'	es 2 No	8d. Describe how	injury occurred				
Division	r Attandii er death. rector: A by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj	ury - At home, farm, str c. (Specify)	reet, factory, office	2	8f. Location (Stree City or Town, S	at and Number or Rura	I Route Number,			
Ö	itel or A irs after rat Directed in by												
	To tha Hospitel or Attanding within 24 hours after death.  To tha Funaral Director: After completely filled in by the fune.	Medical	(Check only 2   Medical Examone)		of my knowledge, deat f examination and/or in ated.								
)	To t To 1	Σ	29b. Signature and title of certifier	shop!		29c. License	number 426	29d.	Date signed (Month,	Day, Year)			
	5H	-	30 Name and address of person who	ampleted cause of d	leath (Item 23a) (Type.	Print) Gree	ue St i	3427700	re nes 2	1201			
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	learn (Item 23a) (Type,	W	·						

December   Company   Com				For State Registrar	State of Marylan		artment of He			iene	18686
Second   Processor   Process		Physici	an	1. Decedent's Name (First, Middle,						Day Year	F == 0
Final Part   P				4a. Facility Name (If not institution,			4b. City, Town, or L	ocation of Death	AONE		
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The proposed of the particular		3a or	al Dir	71	een Ln.			21			country?
The proposed of the particular		tems ?	uner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto F	cify Yes or No- Rican, etc.)		
Emeratory (Secondary (n.12)   College (1-4or S+)   Fabrication   Fabri	036	ours afte	b	•	II Tes, Give						1 1
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A Donasticn S Chenk (Specify)   Part   Par		s 1 and if Healt item 2 other		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of	. D			
Physician Medical Examiner  23a. Part. Enter the diblase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine.  25a. Part. Enter the diblase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Orise and Death (Interval Between Orise) and Deat	timo	Page Iment c tant: If jury or		`4 ☐ Donation 5 ☐ Other (Sp.	ecity)			1	,- 05	Parkville	MD.
Physician Medical Examiner  Physician Active Medical Examiner  Physician Medical Examiner  Physician Active Medical Examiner  Physician Active Medical Examiner  Physician Medical Examiner  Physician Medical Examiner  Physician Active Medical Examiner  Physican Active Medical Examiner  Physician Active Medical Examiner  Physician Active Medical Examiner  Physician Active Medical Examiner  Physican Active Medical Examiner  Physican Active Medical E	Ball	permit Depart Import any in	3	21. Signatu Fareral service L	censee	Ş	onnelly to	of Facility Ho	me of i		
Physician Medical Examiner    Page   Physician   Physi				snock, or near failure. List o	complications that caused the death	n. Do not en	ter the mode of dying,	such as cardiac or	r respiratory arre	est,	Interval Between
Sequentially ist conditions:    Sequentially ist conditions:   Sequentially istance:   Sequentially is				disease or condition	a. OGLIVI	USS	2/NJ	nomt			unkindion
Due to (or as a consequence of):    Comparison of the constraint o	ı	Examiner		Sequentially list conditions.	CNNONIC	NE	Spira	lovy f	FAILU	ne	5 months
Due to (or as a consequence of):    Comparison of the constraint o		nsit	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):	) nA) -	6011	1111 1	5,	Emark 4
FEMALE: 23b. Was decodent pregnant in the past 12 months?   1   yes   2   No   2   Fetal death   4   Pregnant at time of death   9   Unknown   9   Unknown   9   Unknown   1   yes   2   No   9   Unknown   2   St. Was as decodent pregnant   1   yes   2   No   9   Unknown   2   St. Was as decodent pregnant   1   yes   2   No   9   Unknown   9   Unknown   9   Unknown   9   Unknown   1   yes   2   No   9   Unknown   2   St. Was as a referred to medical examiner?   1   yes   2   No   1	oʻ	e execu an and rrial-tra		that initiated events	Due to (or as a consequ	uence of):	Jan 1	TYL		<i></i>	O moning
25. Was case referred to medical examiner?  1	9289	physicist the pr	dlcal		d						
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25. Was case referred to medical examiner?  1		the deat y the atte	nysicia	1 ☐ Yes 2 ☐ No	4□Pregnant at time of de					Month	Day Year
25. Was case referred to medical examiner?  1		ires that signed b	þ	Part fl. Other significant condition	s contributing to death but not resu	ulting in the u	nderlying cause given	in Part I.		- /	
25. Was case referred to medical examiner?  1	cor	s been s been s shoul	oletec							~~	
The state of the s	I Re		Com						perform	ned?   death?	Ł.
The state of the s	Vita	sician: certific irector,	Be	examiner?	Hospital:	5000	Othor				
Second Properties of the Control o				27. Manner of Death	28a. Date of Injury	28b. Time o	IL SLI DOA	4   Nursing non			ecify)
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Check only and manner continued to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	Sion	ttendir death. tor: Af the fur	catic	2 ☐ Accident investiga	ation		M 1 □ Ye	s 2 🗆 No	201		
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Check only and manner continued to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	Div	5 # # G	Sertif		building, etc. (Specify	me, tarm, st /)	reet, factory, office	2	City or Town,	eet and Number or F , State)	Rural Houte Number,
29b. Signature and fittle of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30 Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  Registrar  31. Date filed (Month, Day, Year)  32. Pigistrar's Signature  Registrar		he Hospit n 24 hour he Funera pletely fills		(Check only 2   Medical E	xammer: On the basis of examinat	wledge, deat tion and/or in	h occurred at the time vestigation, in my opir	, date and place, a nion, death occurre	nd due to the ca d at the time, da	use(s) and manner a ite and place, and di	as stated. ue to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State Registrar  JUN 0 3 2005  Registrars  JUN 0 3 2005		of with a	Σ	29b Signature and little of certifier		2	29c. License r	number	29	d. Date signed (Mor	nth, Day, Year)
State Registrar  JUN 0 3 2005  State Registrar  State Registrar	,	9		30. Name and address of person w	tho completed cause of death (Item	23a) (Tyne	Print)	26	J	ure 1	, NOOS
State 31. Date filed (Month, Day, Year) 32. Projectrar's Signature  Registrar  JUN 0 3 2005	10	}		JUMIAT BOW	ACUM 3015	SYPI	9Ur PL	Ball	ImD	WE MI	21VOC
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			_ For	Pleas	<b>se Type o</b> State			d / Depa	artmen	t of H	ealth and	<b>All Copie</b> Mental H			gible.	10007
			State Registrar					Cei	rtificat	e of L	Death		Reg.	No:	UU	10507
	Physicia	an	1. Decedent's Nam	ne <i>(First, Middl</i> e, m Walter		16						2. Date of D Month June	3	Day	2005	3. Time of Death 2139 M
	/Medic Examin		4a. Facility Name (						4b. City, Town, or Location of Death					4c. Cou	inty of Deat	h
			Union M	emorial	Hospita	1			Ba1t	imor	e City		I	3alt	imore	City
	Funeral		5. Social Security !	Number	6. Sex 1 ፟ M 2 ☐ F			st birthday)	If Under Months		If Under 24 Hr Hours Mir		Birth Day, Ye	ear)	9. Birtl	nplace (State or Foreign untry)
	Director		218-40-0		1 <u>M</u> M 2 <u>L</u> F			62 Yrs.				Aug. 2	, 1	942	Penn	sylvania
7	2 3	-	Usual Residence of 10a. State	10b. County			10c. City	, Town or Lo	cation							10d. Inside City Limits
do a	rary e de la	ច់		Baltin			D = 1 +	d m a se a								1 ☐ Yes 2X No
4	286-	ect	MD 10e. Street and Nu		1016		вать	imore	10f. Zip	Code			10g.	Citizen	of What Co	untry?
1	30 or	Funeral Director							212	27			II-		d Ctor	
4	me 2;	era	500 Fif	LII AVE.	12. Was D	ecedent I	Ever in U.S	6. 13.			ispanic Origin? (	(Specify Yes or herto Rican, etc.)		14.1		rican Indian,
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2	ner in	by	3 🗌 Widowed	4 ☐Divorced	If Yes, Year o	r Dates:			⊺ ⊔ res	ZIAINO	Specify:			Spe	ec <i>ify:</i> Whi	Le
ה ה	natu	Completed	(Spe	15. Decedent's	s Education	ed)		16a. Deced (Give	dent's Usu kind of wo	al Occupa rk done d	ation during most of w f)	rorking	16t	o. Kind o	f Business/	Industry
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V	led w lygier her ti		12th 17. Father's Name	(Circt Middle I	act)			Cab_	Drive	r	19 Mother's N	ame (First, Midd			portai	ion
מובר מובר	ad of	Be		•								unknown]		06/1 50/1	name)	
Š	should be lied within 7z hours after death with the maryland ind Mental Hygiene. In a marked other than "natural", or iteme 23e or 28e-f show imprised other than "natural", or itemetic event, the Madical Examiner must be notified at	2	19a, Informant's N	William		ıg		10h Mailir	na Addraes	(Street		Rural Route Num		ity or To	wn State 2	in Code)
	th and 7 ler treur					11 E c			•						W//, Oldio, 2	up Godo)
ນ໌ ເ	Heal Heal em 2		Mildred  20a. Method of Dis		Ing / w	ife_	20b. Pl	ace of Dispo metery, crei	TT LTI osition (Nai	ne of	3 6 1	ore, MD			on - City or	Town, State
2	nt of nt of t: if it			2 XCremation 5 ☐ Other (Sp		om State					100	e 4, 005	D -	1 _ 4 _		MD
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ם מ	Departing Important Important Important Important Important Information Important Impo		1000	16	Low	1		100	Kirk1	ey-R	uddick	Funeral	Hon	ne P	.A.	MD 21061
			23a. Part1. Enter	the disease, or	complications th	at caused	the death								11110	Approximate Interval Between
,	hysician		Immediate Cause		only one cause o	on each iir	1e.	١	.1.	,						Onset and Death
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ດ .	be executed sicien and burial-transit	ai E	Tooling III down	, 2201	Due	to (or as	a consequ	erice or):								
	physi the t				d									<u>_</u>		
o ;	death certificate e attending physi d for use as the b	Physician/Medic	IF FEMALE:		23c. If yes,	outcome	of pregnar	ncy						23d	Date of deli	iverv
ם מ	atter I for u	ciar	23b. Was decede in the past 1: 1 Yes 2	2 months?	4□Pr	egnant at	2 Fetal		∃Ectopic p ∃ Other <i>(s</i> ;		·		_		Month	Day Year
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cords,	quire en sig uld b											1[	Yes	2 🗆 N	o 3 ☐ Pr	obably 4 Onknown
ပ္သ မ	aw re	Completed										24a. W	as an	24	4b. Were au	topsy findings available completion of cause of
ř,	The te ha	mo:											rfòrmed		death?	
VITA	icien: Th certificate rector, pag	BeC	25. Was case reference	erred to medical		-						eath (Check onl	y one)			
0	Physicien: rthis certific ral director,	ု	1 Tes 2			Inpatie	-	ER/Outpatier			4 🗀 lantaning	Home 5□Re				cify)
	ing ing	on:	27. Manner of Dea	5 Pending	, (A	ate of Inju Aonth, Da	y Year)	28b. Time o Injury	M .	28c. Injun Wor	yat k? Yes 2 □ No	28d. Describ	e now	injury oc	curred	
S	r Attending F er death. rector: After by the funer	icat	2 Accident 3 Suicide	investig 6 ☐ Could n	ot be	lace of Ini	ury - At ho	me, farm, st			192 5 140	28f. Location	(Stree	at and Ni	umber or Ru	ıral Route Number,
UIVISION	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	ertification;	4 🗌 Homicide	determi	ned bi	uilding, et	c. (Specify	)	, , , , , , , , , , , , , , , , , , , ,	y, omoo		City or 1	Town, S	State)		
	spita sours nerel	O	29a. Certifier									ce, and due to the				
	na Ho n 24 h	edical	(Check only one)	2 Medical E		ne basis of nanner sta		ion and/or in	vestigation	n, in my o	pinion, death oc	curred at the tim	e, date	and pla	ce, and due	to the cause(s)
	To the within To the Comp	ž	29b. Signature an	d-title of certifier	,		_		29	c. Licens	e number		29d.	Date si	gned (Monti	h, Day, Year)
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1	0		30. Name and ad													
	w		GAUT 31. Date filed (Mo		WLAT1	M.D.	ar's Signat	DIE. V	MUERS	TY P	wwy B.	TLTIMORE	, Mr	2	1218	
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			For State Registrar			d / Depa	artment of h	lealth a		lental Hygi	ene	) 5	186	88
			Decedent's Name (First, Middle, La	st)						2. Date of Death			3. Time of	Death
	Physicia		Dorothy M. Web	er						May 23,	2005	Year	1:00	AM <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, given	e street and numb	er)		4b. City, Town, or Location of Death				4c. Count	y of Death		
	LAUIIIII	Ξ'	Calvert Manor H	ealthcar <i>e</i>	2	Rising Sun					Ce	ecil		
	Funeral Director		5. Social Security Number 6. S 213–38–6768	Sex 7. 1□M 2∏F	Age (In yrs. 87	last birthday) Yrs.	If Under 1 Year Months Days	If Under	24 Hrs. Min.	8. Date of Birth (Month, Day, Jan 28,	Year) 1918	Cour	lace (State o ntry) Jerse	
	g		Usual Residence of Decedent		10. 00	-							0.1 111- 01	h . I . I . I
	within 72 hours after death with the Maryland ene. than "natural", or Itame 23a or 28a-f show fre Madical Examinar must be notified at	_	10a. State 10b. County		Toc. City	, Town or Lo						1	0d. Inside Ci	•
	8a-f	Director	MD Ceci	.1		North							1 🗌 Yes	X
	or 2		10e. Street and Number				10f. Zip Code	01011		10	g. Citizen of		itry?	
	ath w	E	101 Jethro Stre					21911			US			
	ar de tamé	Funeral	11. Marital Status	12. Was Deced	es?	S. 13.	Was Decedent of I If Yes, specify Cub	lispanic Ori an, Mexican	gin? (Spe 1, Puerto	ecity Yes or No- Rican, etc.)		ce - Americ Ick, White,		
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Tes 2			1 ☐ Yes 2🌠 No	Specify:			Speci	fy: wh	ite	
21215-0036	hour	p p	15. Decedent's E	Year or Date		16a Dacer	dent's Usual Occur	nation		1	6b. Kind of E	Rusiness/In	dustry	
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12	withi ene. than	шс	Elementary/Secondary (0-12)	College (1-4	or 5+)	homen	aker	•			own	home		
5	filed Hygi other		17. Father's Name (First, Middle, Las			i i o ii o ii		18. Mothe	er's Name	e (First, Middle, M				
an	d be ental ked c	To Be	John Jack Ke	lley					Ma	y Dubose				
Maryland	shoul nd M mari	-	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street	and Numbe			City or Town	, State, Zip	Code)	
S	Ith at 27 is		Larry Weber/son			2401	E. Parr	is Dr	ive '	Wilmingt	on, DE	198	80	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural; or Itame 53a or 28a-f show any fujury or other treumatic event, Ite Madical Examinat must be notified at once.		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Special Control of Cont			lace of Dispo emetery, crer	sition (Name of matory or other pla	ce)		Date 2	Oc. Location	· City or To	own, State	
Balti	permit. Departm Importe any inju	21. Signature of Fineral Service Seeding State Anatomy Board 655 W Baltimore, MD 21201									Balt	imore	Stree	t
			23a. Part1. Inter the disease, or con	prications that cau	used the deat						st,		Approximate Interval Bet	e ween
	Physician i		shock, & heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Dementic DE Alzheimer's Type  Years											
	/Medical		resulting in death)	a	r as a conseq	uence of):	1 10.10.		2	tre			2011 2	
	Examiner		Out the list and distance	b								4		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter under vivo		r as a conseq	uence of):								
	cuted nd ransi	Examiner	cause. Enter Uniderlying Cause (Disease or injury that initiated events	c										
Ö,	be executed sician and burial-transit		resulting in death) Last	Due to (or	r as a conseq	uence of):								
3760,	# × 6	Ical		d										
89	The law requires that the death certificat ite has been signed by the attending phy agge 2 should be detached for use as th	Med	IF FEMALE:										700	
Вох	th ce	Physician/M	23b. Was decedent pregnant in the past 12 months?		th 2 Feta	I death 3	Ectopic pregnanc	у				ate of delive onth		rear .
	e dea the at	200	1 ☐ Yes 2 🗷 No	4☐Pregnar	nt at time of d vn	eath 5	Other (specify) _					37111	Duy	Jul
P.0	that the de led by the a detached f	Phy	9 Unknown		Ab 6	Min In Man		'- B-41		23e. Did toba	2000 1100 000	utributa ta ti	an anyon of d	ooth?
	res the iigned be de	by	Part II. Other significant conditions	toid A		•	ndenying cause gr	venin Pan i	•	1 🗆 Yes	-	3 Prob		Jnknown
Vital Records,	w requir been si should	Completed	10.1601/12	WIC N	121 ( 10 1	115						- 0	abiy 4 🗀 c	THE TOWN
ec	has b	nple								24a. Was an autopsy		prior to con	psy findings : mpletion of ca	available ause of
<u> </u>		Con								perform 1 ☐ Yes 2	No	death? 1 ☐ Yes	2 □ No	
/ita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	I les-itals			104	4.7		h (Check only one				
of\	Physi this c	ို	1 ☐ Yes 2 No	The same of the sa		ER/Outpatier	11 3∐ DUA		-	me 5 Resider			y)	
ם		on:	27. Manner of Death  1 X Natural 5 ☐ Pending	28a. Date of (Month)	Day Year)	28b. Time o Injury	Wo			28d. Oescribe hov	v injury occu	rrea		
sio	Attending or death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not	00				]Yes 2□		ORL Landing (Ct.		had as Over	I Davida Muse	
Division	or At fter d Sirect in by	ertification;	4 Homicide determine	289. Place o	g, etc. (Specif	ome, farm, sti	reet, factory, office			281. Location (Street) City or Town,		ber or Hura	u Houte Num	der,
	urs a urs a srai t	O	OCO CONTINUE DE CONTINUE DE	busines To the b			h accurred at the 1	data as	d alone	and due to the no.	.a.(a) and -		lated	
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the b miner: On the bas and manne	is of examina	ition and/or in	vestigation, in my	opinion, dea	id place, ith occuri	red at the time, da	te and place	and due to	the cause(s	)
	To the within To the comp	Ň	29b. Signature and title of certifier	0			29c. Licen	se number	820	29	d. Date sign	ed (Month,	Day, Year)	
			Meil 2. 7	a			17	JU 3	03,	24	2/93	5/05		
			30. Name and address of person who	completed cause	of death (Iten	п 23а) Пуре.	Print)			0.10				
				NIAL 32. Re	Way	IKI	sing Du	en, V	NI	2191	1			
	Sta		31. Date filed (Month, Day, Year)	82. Re	gistrar's Signa	ture	W.							
	Regist	rar	JUN 0 3 200			7								

			For State Registrar	State of M	•	Department o Certificate o	f Health and I of Death	•	giene Reg. No. 005	18689
	Physicia /Medic		Decedent's Name (First, Midd.  EDNA C. WARD	le, Last)				2. Date of De Month	ath Day Year	3. Time of Death
	Examin		4a. Facility Name (If not institution) Mak Hand	n, give street and number)	Hospit	al Ab City, Tow	n, or Location of Death		4c. County of Dea	ath
	Funeral Director		5. Social Security Number 217-16-4101	6. Sex 7. Ag 1 □ M 23☑ F	ge (In yrs. last bin		ear If Under 24 Hrs. ays Hours Min.	B. Date of Bird (Month, Da	y, Year) C	rthplace (State or Foreign ountry)
	yland Now		Usual Residence of Decedent  10a. State 10b. County	1	10c. City, Town	n or Location				10d. Inside City Limits
	r 28a-f ehow	Director	MD	<del>~.</del>		BALTIMOR		····		1 X Yes 2 □ No
	th with th		10e. Street and Number 3219 MASSACHUS	ETTTC AVE		10f. Zip Coo 212		r	10g. Citizen of What C	ountry?
	s after death v , or Items 23 caminat must	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.		of Hispanic Origin? (S Cuban, Mexican, Puert			
036	within 72 hours after death with the Maryland ane. then "naturel", or tems 23a or 28a-f ehow he Madical Examinar must be nuclified at	þ	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	rried 1 ☐ Yes 2√☐	No	1 ☐ Yes 2 🛣			Specific	BLACK
RCd	s 1 and 2 should be filed within 72 hours Health and Mental Hygiene. Item 27 Ie marked other then "naturel", other treumatic event, the Medical Exa	Completed	(Specify only highe	nt's Education est grade completed)		Decedent's Usual Oc (Give kind of work do life. DO NOT use re	ccupation one during most of wor stired)	rking	16b. Kind of Business	s/industry
120	ed with /giene. ier ther t, the h	Com	Elementary/Secondary (0-12)	College (1-4or	5+)	NURSE			HEALTH CA	RE
$ng$ $\mathcal U$ Maryland	d be fill ental Hy ced oth c even	o Be	<ol> <li>Father's Name (First, Middle, CORNELIUS DEAN</li> </ol>				18. Mother's Nar		, Maiden Sumame)	
ary	shout and Me le mark	Ĕ	19a. Informant's Name/Relations		19b	. Mailing Address (Str			er, City or Town, State,	Zip Code)
	1 and 2 Health sm 27 I		MADELINE S. NOR	TON/DAUGHTER			. APT lA B	alto., N	MD 21216 20c. Location - City of	r Town State
$\mathcal{R}_{\mathcal{U}}$ altimore,	Pages nent of I nt; If its ry or o		1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (5			Disposition (Name or ry, crematory or other and Nationa	place) 1 Cem↓ 6-6		LAUREL, MD	
Balti	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 ie marked other then any injury or other treumatic event, the Ms once.		21. Signatur of Funeral Service	Licensee	, in I I was	William C	ddress of Facility Brown CO	mmunity	FUneral Ho	
			23a, Part1. Enter the disease, of shock, or heart failure. Lis	r complications that cause	d the death. Do r		orth Ave. dying, such as cardiad			Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Septi	c Si	hock				Onset and Death
ايط	Examiner			Bila:	ARA (	Paro	+1+13			
18	nted I	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of): + To-	Cation	•		
30,	icate be executed physician and s the burial-transit		that initiated events resulting in death) Last	Due to (or a	onsequence	of):	7007			
68760,	ficate phys s the	edical		d						
Box	sath certii attending for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death				23d. Date of de	elivery Day Year
o.	that the de ed by the a detached	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant a 9□ Unknown	t time of death	5 ☐ Other (specify	//			
of Vital Records, P.O.	To the Hospitel or Attending Physicien: The law requires that the death certi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a		Part II. Other significant conditions and the CER COLOUSE	ions contributing to death!	out not resulting in	n the underlying cause	given in Part I. MENTIA		obacco use contribute t Yes 2 ☐ No 3 ☐ P	o the cause of death?
Reco	sicien: The law re certificate has be irector, page 2 sho	Completed by							osy prior to death?	utopsy findings available completion of cause of
/ital	ysicien: " is certifica director, p	BeC	25. Was case referred to medica examiner?					1 ☐ Yes ath (Check only o		S ZUIVO
of	Physi er this c eral dire	n; To	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpati	ury 28b. 7		Other: 4 Nursing H Injury at Work?		dence 6 Other (Spe	ecity)
Sivision on the sign of the si	tending Fleath. tor: After the funer	catlo	1 Natural 5 Pendi 2 Accident invest 3 Suicide 6 Could	igation		М	1 ☐ Yes 2 ☐ No			
	s after of all Directed in by	Certification;	4  Homicide determ	mined 200. Fiace of In	jury - At home, fa tc. (Specify)	rm, street, factory, off	fice	28f. Location (: City or To	Street and Number or R wn, State)	Rural Route Number,
	To the Hospitel or Attendi within 24 hours atter death. To the Funeral Director: A completely filled in by the te	edical	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ng Physician: To the best I Examiner: On the basis of and manner s	of examination an	e, death occurred at the d/or investigation, in r	ne time, date and place my opinion, death occu	e, and due to the urred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the To the comp	ž	29b. Signature and title of certific	olliet	sher	29c. Lic	cense number		29d. Date signed (Mon	th, Day, Year)
	1		30. Name and address of person	who completed cause of	death (Item 23a)	(Type, Print)	May	bad	Genera A	Nontro
	Sta	ate	31. Date filed (Month, Day, Year UN 0 3 2)	7 00 01 () () () () () () () () () () () () ()	rar's Signature	1110 70	Mary	1WILL	UTGHU	HUZITUL
	Regist	rar	JOH 03 20	JUS Medican	J. A	ander				

			For State Registrar	State of Ma	•	•	rtment of He tificate of D		_	giene	5	18690
Ī	Physicia	an	1. Decedent's Name (First, Middle, Last)						2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	Dean Watts  4a. Facility Name (If not institution, give s	tmot and number			4b. City, Town, or	coation of Da	May	25 2 4c. County	005	3:30 A <sup>M</sup>
	Examin		Knollwood Manor	Nursing		70	Millers			Anne	Aru	nde1
	Funeral Director			M 2□F	o (In yrs. last birth 51 Y	rs.	Months Days	Hours Mi	n. 8. Date of Bir AUG 2	6 Year) 953	Mar	yland
	and ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Loc	ation				1	0d. Inside City Limits
	Mary -1 she	ţō	Maryland N/A		Balt	im	ore					1 ☐ Yes 2 🌠 No
	or 28e	Directo	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?
	ath wi		1107 Lanvale Dr		-		21257			USA		
<u>9</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28e-f show empty injury or other treumatic event, Ite Madical Erapinar must be putilised at pDGs.	y Funeral	X Never Married 2 Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 XN If Yes, Give		If	/as Decedent of His Yes, specify Cubar ☐ Yes 2√ No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	Bla	ck, White,	etc.
21215-0036	hours turel',	ed by	3 Widowed 4 Divorced	Year or Dates:	16a I		ent's Usual Occupa	tion		16b. Kind of B		
<u>.</u>	n "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)			(Give k	kind of work done di O NOT use retired)	uring most of w	vorking	100.11110	301110004111	
212	giene giene er tha	Com	12th	O	(**)	C	ook					der Care
2	al Hy	Be C	17. Father's Name (First, Middle, Last)						ame (First, Middle		ne)	
<u>\</u>	ould to	2	David Watts		401				Mae Jon		O-4- T-	0-4-)
Maryland	d 2 sh th and 7 is n treum		19a. Informant's Name/Relationship (Ty. Nadine Thomas (N				g Address <i>(Str</i> eet a. Galetowr		Severn	-		
ē,	Heal Heal tem 2		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	20b. Place of	Dispos		1	Date	20c. Location		
9	Pages ent of nt: If i		1 ☐ Burial 2 XCremation 3 ☐ R  1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	3		ematory		1-05	Balti:	more	, Md.
Baltimore,	permit. Departm Importa eny inju		21. Signature of Funeral Service License	ese MOC	483	Wi 8	Name and Address M. Reese 21 West	s of Eacility S S S O	ns Mort	uary,	P.A.	∩1
8760,	/Medical bubysician and street be executed bubysician and street street street bubysician and street bubysicia	dical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of	f): ():	mune l	7 <b>.</b>		7,00		8 YEAKS
.O. Box 68	death certifi e attending id for use as	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)				ate of deliver	ery Day Year
0	es De	by Ph	Part II. Other significant conditions con	ntributing to death b	ut not resulting in	the un	derlying cause give	n in Part I.				he cause of death?
ord	w requir been si should	eted										
l Records,	(0	Completed							24a. Was auto perfo			psy findings available mpletion of cause of
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe		eath (Check only			
of	d is	To.	1 Yes 2 No	1 ☐ Inpatie		-	28c. Injury Work	4 Nursing	Home 5 ☐ Resi	dence 6 Ot how injury occu		(y)
OU	Attending Ph r death. sctor: After th by the funeral	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year) In	ijury		? ′es 2 □ No				
Division		ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At home, far c. (Specify)	m, stre	eet, factory, office			Street and Num wn, State)	ber or Rura	al Route Number,
_	Hospite 4 hours Funerel ely filled	edical C	29a. Certifier (Check only one)  1 Certifying Phy 2 Medicel Exemi	sicien: To the best ner: On the basis o and manner st	f examination and	, death Vor inv	occurred at the tim restigation, in my op	e, date and pla inion, death o	ace, and due to the ccurred at the time,	cause(s) and m date and place,	anner as s and due t	tated. the cause(s)
	To the within 2.	Me	29b. Signature and title of certifier				29c. License	number		29d. Date sign	ed (Month,	Day, Year)
			1 Bi Cul	ellau	- hus		D3/	136		JUNE	1,20	205
	3	-	30. Name and address of person who co	ompleted cause of c	leath (Item 23a) (	Туре, І	Print)		05 2.			21236
			31. Date filed (Month, Day, Year)	CACE V	ar's Signature	5	KILBA	TIDE F	CU, BAI	TIMORI	> m	0 01436
	Sta Regist		IIII 0 2 21	105	***	40					•	

Harold Baker 05-03374

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🖺 🗅 🚞

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	i. Decedents i
Physician /Medical	Haro
Examiner	4a. Facility Nar
	Atla

**Funeral** 

Director

permit. Peges 1 and 2 should be filled within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Item 271s marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Modical Expirient must be notified at agree. Baltimore, Maryland 21215-0036 Physician /Medical Examiner been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, State Registrar

	1 = State Registrar			Certif	ficate of	Death		Reg. No	UU	J	1009	
	1. Decedent's Name (First, Middle, Las	t)					2. Date of De		v	Vear	3. Time of Dea	th
n al	Harold Milton Ba	aker					May May	15	' 20	Ŏ5°	1350	М
er	4a. Facility Name (If not institution, give	street and nur	nber)	41	b. City, Town, or	r Location of Death	1	4c.	. County	of Death		
	Atlantic Genera		Ltal		Berlin				Worc	este	r	
	214-46-4301	ex □ <b>X</b> M 2□ F	7. Age (In yrs. last bi		f Under 1 Year lonths Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da April	y, Year)	946	Cou		reign
	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	n or Locati	ion						10d. Inside City Lin	mits
ŏ	MD Worcest	ton									1 ☐ Yes 2 ∑	
S S	MD Worcest  10e, Street and Number	rei	3100	kton	10f. Zip Code			10a Cit	izen of W	Vhat Cou	nto/?	
Funeral Director	1422 Snow Hill R	d.			21864	ŀ			USA		id y .	
ne	11. Marital Status	12. Was Dece Armed Fo	dent Ever in U.S.	13. Was	Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No	-		e - Ameri k, White,	can Indian,	
	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 [XYes If Yes, Giv Year or D:		10	Yes 2 □XNo	Specify:	, ,		Specify		nite	
Completed by	15. Decedent's Edi	ucation		. Decedent	r's Usual Occup	ation during most of work	king	16b. K	ind of Bu	siness/In	dustry	
nple	Elementary/Secondary (0-12)	College (1	-4or 5+)	life. DO	NOT use retired	1)	King					
င်္ပ		3	<u> </u>	Stat	e Police	Officer				e Po	lice	
Be	17. Father's Name (First, Middle, Last)					18. Mother's Nam			Sumam	Θ)		
٥	Milton M. Baker  19a. Informant's Name/Relationship (T	vne Print)	191	Mailing A	ddress (Street	Winifr and Number or Ru	ed Rile		of Tours	State 7in	Code	
	Cathy C. Baker										(Code)	
	20a. Method of Disposition		20b. Place of	f Dispositio	now Hil on (Name of ory or other place		tockton Date	•			own, State	
	1 X Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,		State		Cemete		9/05	Gi	irdle	tree	, MD	
	21. Signar re une diservice Licens	24.60		22. Na	ame and Addres	ss of Facility Dage Fun ms St.	eral Ho	me				
	23a. Part1. Enter the disease, of comp shock, or heart failure. List only of	lications that c	aused the death. Do	not enter th	ne mode of dyin	g, such as cardiac	or respiratory ar	rrest,	2181		Approximate	
	Immediate Cause (Final	ne cause	ach line	00	721		)				Interval Between Onset and Death	
	disease or condition resulting in death)	aDue to (	or as a consequence	of):	Troje	vues			-			
				0.7.	U							
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Usease or injury	Due to (	or as a consequence	of):								
Examiner	that initiated events resulting in death) Last	с.										
	resulting in death) Last	Due to (	or as a consequence	of):								
edical		d										
Me	IF FEMALE:	22a If yas out	come of pregnancy									
าลก	in the past 12 months?	1☐Live b	irth 2 Fetal death ant at time of death		opic pregnancy her (specify)			1	23d. Date Mor	e of delive 1th	ery Day Year	
Physician	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno		3 🗆 0 (	пет (эреспу)							
Dy Pr	Part II. Other significant conditions co	ntributing to de	eath but not resulting i	n the under	rlying cause give	en in Part I.	23e. Did to	obacco u	ise contri	ibute to th	he cause of death?	?
D D							1 🗆 Y	/es 2)	<b>⊠</b> No	3 🗌 Prob	ably 4 Unkno	own
Completed							24a. Was	an	24b. W	Vere auto	psy findings availa	able
E								rmed?	P P	rior to co eath?	mpletion of cause	of
ധ	25. Was case referred to medical					26. Place of Deat		2 No	<u>/</u>	∠¥es	2 🗆 No	
0	examiner? 1 X Yes 2 □ No	Hospital: 1 🗆 II	npatient 2 XER/O	tpatient 3	DOA Othe		ome 5 Resid		6 □Othe	r (Specif	v)	
ü	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of		Time of	28c. Injury Work		28d. Describe h	now injur	y occurre	ed )	un movee	
ation	2 Accident investigation	5-1:				Yes 2 No	Strull			- 17	_	
ertific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place buildir	of Injury - At home, fang, etc. (Specify)	ırm, street,	factory, office		28f. Location (5 City or Tow	Street an vn, State	d Numbe	or or Rura	Black land	119
<b>U</b>			V00	ia			Rdard	Row	te 12	word	hesterlo, t	口
edical	29a. Certifier 1 ☐ Certifying Phy (Check only one)  1 ☐ Certifying Phy 2 ☒ Medical Exami	rsician: To the iner: On the ba and mann	best of my knowledge sis of examination ar er stated.	e, death oca d/or investi	curred at the timi igation, in my or	ne, date and place, pinion, death occur	and due to the or red at the time, or	cause(s) date and	and mar I place, a	nner as si nd due to	ated. the cause(s)	
Z	29b. Signature and title of certifier		1.		29c. License	number MF					Day, Year)	
	MILA	1	M							200		
	30. Name and address of person who co	ompleted daus	e of death (Item 23a)	(Type, Prin	t) I11 Popr	Stroot	Rol+im	020	Max	·v1	d 21201	
	5, 8, 1400	TAR	/		TTT LEUI	1 Street	Daltill	ore,	rial	у таг	IG ZIZOI	

31. Date filod (Month, Day, Year)

MAY 1 9 2005

			1 - For State Registrar	State of Maryland		artment of rtificate of			giene () () 5 leg. No.	18692
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ith Day Year	3. Time of Death
	/Medic		Walter	E. Brummel	.1,	Jr.			4, 2005	0540 M
	Examin	er	4a. Facility Name (If not institution, give s			4b. City, Town	n, or Location of Dea	ıth	4c. County of Dea	
			Talbot Hospice  5. Social Security Number 6. Sex		and brings along	Eas If Under 1 Ye		s   s =	Talbo	
	Funeral Director			7. Age (In yrs. la	Yrs.	Months Da			(Year)	rthplace (State or Foreign ountry)  laware
	/land low		10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-f show he Maylcal Examirer must be notified at	tor	MD Talbo	t		Cordo	o <b>v</b> a			1 ☐ Yes 2 No
	th the	Director	10e. Sireet and Number			10f. Zip Cod	е		log. Citizen of Whal C	ountry?
	23a c	ai D	10792 Lewistown	Road		1	21625	1	United St	ates
	r dea	Funerai	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of	of Hispanic Origin? ( Suban, Mexican, Pue	Specify Yes or No-	14. Race - Am Black, Wh	
30	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🖈 No If Yes, Give		1 ☐ Yes 2 📆 !		,,		Black
1215-0036	hour tural	ed b	15. Decedent's Educ	Year or Dates:	160 Door	dentia Liquel Oe				
Ċ	in 72 in 72	ojet	(Specify only highest grade	completed)	(Give	dent's Usual Oc kind of work do DO NOT use rei	ne during most of wo		16b. Kind of Business Canning H	
77		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Fact	ory Wo	orker		Auto Fac	tory
p	# # # # # # # # # # # # # # # # # # #	Be C	17. Father's Name (First, Middle, Last)					me (First, Middle,		-
<u>a</u>	uld be Mental rrked o	ToE	Walter E. Brum	mell, Sr.			Elsi	e E. Si	nms Brumn	ell Nichol
, Maryland 2	os 1 and 2 should to of Health and Ment item 27 Is marked r other traumatic of	•	19a. Informant's Name/Relationship (Type Barbara Jones/	,	19b. Mailir 1079	ng Address (Stre	eet and Number or Fi istown R	d., Core	r, City or Town, State,	Zip Code) 21625
baltimore,	Pages 1 a nent of He int: If item iry or othe		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Re 1 □ Donation 5 □ Other (Specify)	ce	metery, crei	osition (Name of matory or other) Hill	place)		20c. Location - City of	
			21. Signature of Funeral Service License				i			
ñ	permit. Departr Imports any inje		Mulley 7. 9	Elsen	2	216 N. M	lain St.,	ramptom Federalsl	runeral ourg, MD 21	Home, P.A. 1632
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the death.						Approximate Interval Between
ı,	Physician		Immediate Cause (Final disease or condition	/	10	2010	ama			Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of the ros.	ence of):	rue 11	1	10		
	Examiner		Sequentially list conditions	Athers.	scles	ofic	neart	disea	se	
	ם יו	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequent	ence of		1. 1 200	10:	lisease (HIV	1
	icate be executed physician and s the burial-transit	Examine	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequence	150	rriurie	deficier	ing an	130.5541110	)
δĊ,	be ex ician burial			Due to (of as a conseque	ence or):			,		
09/80	physi the l	dicai	d.							
ο Ο Ο	death certificate be executed e attending physician and of for use as the burial-transit	ician/Me	IF FEMALE:	3c. If yes, outcome of pregnan	cv				22.5.4.	
ñ	atter I for u	ciar	in the past 12 months?	1 Live birth 2 Fetal ← 4 Pregnant at time of dea	death 3[	Ectopic pregna Other (specify)			23d. Date of de Month	Day Year
j.	the sche	Physi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
 T	requires that een signed b	by P	Part II. Other significant conditions conf	mbuting to death but not resul	ting in the u	nderlying cause	given in Part I.	23e. Did tot	pacco use contribute to	the cause of death?
cords	quire an sig uld b							1 □ Ye	es 2□Nó 3□P	obably 4 Unknown
ပ္ပေ	law re as bec 2 sho	Completed						24a. Was a		itopsy findings available
Ĕ	The I	Ho						autops perform	ned? death?	completion of cause of
VII	sician: The law s certificate has b irector, page 2 s	BeC	25. Was case referred to medical				26. Place of De	ath (Check only on		2LINO
>	hysic nis ce I direc	10	examiner? 1 Yes 2 No	ospital: 1 Inpatient 2 E	R/Outpatien	t 3 DOA	Other: 4 Nursing I	Home 5 Reside	ence 6 Dother (Spe	city) Hospice
10 U	ng Pl		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. ln	jury at Vork?	28d. Describe ho	w injury occurred	
<u> </u>	tendi leath. lor: A	cati	2 Accident investigation 3 Suicide 6 Could not be			M 1	Yes 2 No			
DIVISION	or At after d Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At hon building, elc. (Specify)	ne, farm, str	eet, factory, offic	08	28f. Location (St. City or Town	reet and Number or Ri n, State)	ural Route Number,
	pours sours source sou		29a. Certifier 1 XCertifying Physi	ician: To the best of my know	ledge death	a popular at the	time, date and place	and due to the co	augo(a) and manner as	
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edicai	(Check only 2 Medical Examin	er: On the basis of examination and manner stated.	on and/or inv	vestigation, in m	y opinion, death occi	urred at the time, da	ate and place, and due	to the cause(s)
	To the To the comp	Σ	29b. Signature and lille of confiler	1 MM			ense number		9d. Date signed (Mont	
						1	10566	57	2/18/0	7
			30. Name and address of person who con	poleted cause of death (Item :	23а) (Туре,	Print)	1	0		0 2//1
						tchme	n LANE	1245	10W ,11/1	101601
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re	.00				

DHMH 17 Rev 1/2001

Registrar

32. Registrar's Signature

MAY 1 9 2005

			1 - For State Registrar	State of Maryland /			of Health a	nd Mental Hy	/giene	05 18693
	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Last)     A	eet and number)	_	4b. City. To	wn, or Location of	2. Date of D Month	eath Day	3. Time of Death 200 208 AM
	Funeral Director		5. Social Security Number 230-03-6095 6. Sex	Midical Center  7. Age (In yrs. last)  93	birthday) Yrs.	Augus If Under 1 Y	apolis, 1	70	th Year 1911	n & Anindil
	e Maryland Ba-f show	Director	Usual Residence of Decedent  10a. State  Maryland  Anne Arur	ndel 10c. City, To	own or Loc		Annapoli	S		10d. Inside City Limits 1 ☐ Yes 2 ☑No
	th with the 23a or 2	al Dire	10e. Street and Number 84 North Old Mill E	Sottom Road		10f. Zip Co	21401			f What Country? .S.A.
9036	be filed within 72 hours after death with the Maryland tal Hygiene.  do other than "natural" or items 23e or 28e-1 show event, the Medical Examinar must be rotified at	d by Funeral	11. Marital Status 12  1 □ Never Married 2 □ Married 3   Wildowed 4 □ Divorced	. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		/as Decedent Yes, specify		n? (Specity Yes or N Puerto Rican, etc.)	о- 14. Ra Ві <i>Sp</i> ес	ace - American Indian, ack, White, etc. ify: White
21215-0036	filed within 72 h Hygiene. other then "netu ent, I're Medical	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion 16 completed) 16 College (1-4or 5+)	(Give k. life. Di	O NOT use r	fone during most of etired) tractor		Buildi	Business/Industry ing Construction
Maryland	should be fill ind Mental His marked oth	To Be	17. Father's Name (First, Middle, Last) Henry Clay Brown					s Name <i>(First, Middle</i> Olie Marga		
	nd 2 shill and 27 is m		19a. Informant's Name/Relationship (Types Carol B. Barrett/da				reet and Number Top Cour	or Rural Route Numb t Annapo		
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition  1XX8urial 2 ☐ Cremation 3 ☐ Rer  '4 ☐ Donation 5 ☐ Other (Specify)	ceme	ect I		emetery	Date 5/18/2005	Front	- City or Town, State L Royal, VA
Ball	permit. Pag Department Importent: I any injury o		21. Signature — uneral Service Licenses	Lille	22. 147 س	Name and A 7 Duke	of Glou	John M. 7 cester St.	aylor F Annap	Tuneral Home colis, MD 21401
	Physician /Medical		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	SEIZUM		150,	NDER		arrest,	Approximate Interval Between Onset and Death
	Examiner	_		Due to (or as a consequence	0	F 5	Truk	٤		Wins.
8760, I	cate be executed physician and the burial-transit	Ical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence						
.O. Box 6	death certifi e attending d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown		Ectopic pregn Other (specif			1	ate of delivery Ionth Day Year
ords, P	w requires that the been signed by the should be detache	by	Part II. Other significant conditions contrib	Sion			e given in Part I.		tobacco use cor	ntribute to the cause of death?
of Vital Record	The law ate has b page 2 s	Completed		FIBRILL	AT		)	1 □ Yes	psy prmed? 2 DNo.	Were autopsy findings available prior to completion of cause of death?  1  Yes 2  No
of Vit	di S	To Be	To tes 200 No	pital: 1 Inpatient 2 ER/C			Other: 4 - Nurs	of Death Check onling Home 5 ☐ Res		her (Specify)
Division (	ding h. After fune	ertification;	2 Accident investigation	28a. Date of Injury (Month, Day Year)	. Time of Injury		Injury at Work? 1 ☐ Yes 2 ☐ No		how injury occu	rred
Divi	ospitel or Attendents after deatlenders brector: in filled in by the	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stree	et, factory, of	fice		Street and Num wn, State)	ber or Rural Route Number,
	I 4 II 0	edical	29a. Certifier 1 Certifying Physic (Check only one) 1 Medical Exemine	ian: To the best of my knowled: On the basis of examination a and manner stated.	ge, death o and/or inve	occurred at the stigation, in r	ne time, date and my opinion, death	place, and due to the occurred at the time,	cause(s) and m date and place,	anner as stated. , and due to the cause(s)
)	To the within 2. To the complet	M	29b. Signature and title of certifier		$\geq$	29c. Lie	sense number	41	29d. Date signe	ed (Month, Day, Year)
			30. Name and addre	pleted cause of death (Item 23a	Y Type P	rint)	1 ANN	MPSUS	MA/	SALATA, E.
3	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 8 20	32. Figistrar's Signature		north .	\ DK_ERI	SHCH"	(	

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State	oi iviaryiane		tificate of			Reg. No. 2	05 1	9601.
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day	Year 3.1	Time of Death
,	Physici /Medio		ETHEL CYLESTA BE	RICKERD				MAY	22, 2	005 1	LO:25PM
	Examin		4a. Facility Name (If not institution, give street and no				4b. City, Town, or L		,		
			WALDORF HEALTHCARI	_		If Under 1 Year	WALDORF	-,		ARLES	
Н	<sub>o</sub> Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day	y, Year)		(State or Foreign
	Director		217-36-9648 Usual Residence of Decedent	91				NOV. 2	2,1913	MARYI	AND
	/land		10a. State 10b. County	10c. City,	, Town or Lo	cation				10d. In	side City Limits
-	Mariation Mariation	호	MARYLAND CHARLES	W	ALDOR	F				1[	☐ Yes 2 🂢 No
	th the	Director	10e. Street and Number	·		10f. Zip Code			10g. Citizen of V	Vhat Country?	
	th wi	al	4140 OLD WASHINGTON	ROAD			0602			. A .	
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Department of Heatil and Mental Hygiene. Important: If term 27 is marked other than "netural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evander must be mall ted at once.	Funeral	Armed F  1 □ Never Married 2 □ Married 1 □ Yes  If Yes, G	2 🗓 No		Vas Decedent of H Yes, specify Cub ☐ Yes 2 🔯 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Rac Blac Specify	e - American Ind k, White, etc.	
21215-0020	ural',	d by	3 LXWidowed 4 ☐ Divorced Year or	Dates:	10 5					WHITE	
5	n 72 h	Completed	15. Decedent's Education (Specify only highest grade completed	0	16a. Deced (Give ,	ent's Usual Occup kind of work done DO NOT use retire	pation during most of worl d)	king	160. King of Bi	usiness/Industry	
12	withii ene. than he M	E	Elementary/Secondary (0-12) College	(1-4or 5+)		MAKER	-/		OTATNI	HOME	
D	filed Hygi other ent,	Be Co	17. Father's Name (First, Middle, Last)		HOME	MAKEK	18. Mother's Nam	ne (First, Middle,			***************************************
<u>la</u>	ild be fenta fenta tred	ТоВ	GEORGE ELBERT TAYLOR	R			ETHEL	ELIZA	BETH W	INDSOR	₹
ar)	and N s ma		19a. Informant's Name/Relationship (Type, Print)				and Number or Ru	ral Route Numbe	r, City or Town,	State, Zip Code	))
Ž.	and 2 ealth n 27 i		EDITH BADEN- DAUGHTI	7.6		BADEN		WALDOR		20603	
Baltimore, Maryland	ges 1 t of H if iter or oth		20a. Method of Disposition 1 □ Burial 2 ဩCremation 3 □ Removal from	n State	ace of Dispo- metery, cren	sition (Name of natory or other pla		Date	20c. Location -		
<u>Ħ</u> .	tmen tant: tant:			METROPO	4			5-27-05	ALEXA	NDRIA,	VA
Bal	Depar Depar Impor Impor		21. Signature of Funeral Service Licensee	M00479		Name and Addre	FUNERAL	SERVIC	E, PA		
			Michael O. to	J	LA	PLATA	MARYLA	ND 20	646	A	oximate
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	each line.	. Do not ente	si tile mode or dy	ng, such as cardiac	or respiratory at	1631,	Inten	val Between et and Death
<i>,</i> '	Physician /Medical		Immediate Ceuse (Final	VEMO	A/1 /					FEW	DAYE
	Examiner		disease or condition resulting in death) a		as a conseq						71-13
	₽ #	ner	-			•					
V	tificate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions,	Dua to (or	às à conseq	uenca ot).					
68760,	be ex ician bunal		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.					,			
587	icate phys s the	<b>Aedical</b>	that initiated events resulting in death) Last	Due to (or	as a consequ	uence of):					
			d								
<u> </u>	death cei e attendir ed for use	Physiclan/I	Part II. Other aignificant conditions contributing to	death but not resu	Iting in the ur	iderlying cause giv	ven in Part I.	23b. Did t	obacco use cor	ntribute to the c	cause of death?
P.O.	t the by th tache	hys	WENTER TIA					1 🗆 1	rea 2□ No	3 Probably	4 🗇 thknown
	res that the de signed by the a I be detached f	by	BE10-014141								/
of Vital Records,	law requires that the as been signed by th 2 should be detach	Completed	HYPERTENSIDO	7				24a. Was perfor	en autopsy med?	evailable	topsy findings prior to ion of cause
Ö	e law r has by ge 2 sh	nple								of death?	
E	Pa ate ⊐							1 □ Y	es 2 No	1 ☐ Yes	2□ No
Vit	ysicien: Th is certificate director, pa	Be	25. Was case referred to medical examiner?			Ott	26. Place of Dea				
o	di S	-: To		Inpatient 2□E e of Injury :	EH/Outpatien 28b. Time of	t 3□ DOA Ou 28c. Inju Wo	4/LT Nursing He	ome 5 ☐ Resid	ow injury occurr		
on	ding th. th. After fune	ıtlor	1 Natural 5 ☐ Pending (Mo 2 ☐ Accident investigation	onth, Day Year)	Injury		rk?  Yes 2 □ No				
Division	II or Attending after death. I Director: After d in by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be 28e. Place	ce of Injury - At hor ding, etc. (Specify)	me, farm, stre	eet, factory, office		28f. Location (S City or Tow	Street and Numb	er or Rural Rout	te Number,
ă	al or s afte al Dir	Certification:	4   Homeide   Build	ung, etc. (Specify)	,			0.1, 0.1.0	.,		
	Hospital 24 hours a Funeral I	edical	29a. Certifier (Check only (Check only 2 Medical Examiner: On the	basis of examination	ledge, death on and/or inv	occurred at the ti	me, date and place, ppinion, death occur	, and due to the or rred at the time, o	ause(s) and ma	nner as steted. and due to the c	ause(s)
	the the	Med		nner stated.		29c. Licens			29d. Date signed		
	So Villa		Signature and the or seguine								
			30. Name and address of person who completed cal	use of death Atem	23a) (Tyne	Print)	1 1		1 //3		
	1		A SHVINKUMAR	JPA	TEL	1021	1443 SUL ME	llow C	T, WA	DORFN	4) 20602
	Sta	te		Registrar's Signati	ure				•		

Registrar

JUN 0 3 2005 Beau & Spells

DHMH 16 Rev 6/95

J			State of Maryland / Department of Health and State Unpend Item 23a,27,28a-f per me G844 6-8-05 tas Certificate of Death	Mental Hygie	ne2005 18695
			Decedent's Name (First, Middle, Last)	Reg.	3. Time of Death
п	Physici		DEANIA STEPHANIE CASTO	Month MAY	Day Year
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De		17, 2005 12:17P. M
	_Admin	Ξ.	CIVISTA MEDICAL CENTER LaPLATA		CHARLES
3	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	rs. 8 Date of Birth	9 Birthplace (State or Foreign
Š	Director		212-62-5351 1 M 2X F 43 Yrs. Months Days Hours Mi	n. (Month, Day, Ye MAY 12	,1962 MARYLAND
)	pu *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		
	ehow	5			10d. Inside City Limits 1 ☑Yes 2 ☑ No
	28a-f	Director	MARYLAND CHARLES LA PLATA  10e. Street and Number		
	with	D		10g.	Citizen of What Country?
	ath	Funeral	1 HICKORY LANE         20646           11. Marital Status         12. Was Decedent Ever in U.S.         13. Was Decedent of Hispanic Origin?	(Specify Vac or No	U . S . A . 14. Race - American Indian,
′0	fter dea	F	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No	erto Rican, etc.)	Black, White, etc.
036	hours after urel', or Ite	by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: WHITE
5-0036	72 hours after de "neturel", or Items	ompleted	15. Decedent's Education 16a. Decedent's Usual Occupation	168	p. Kind of Business/Industry
2121	within 7 ene. then "r	nple	(Specify only highest grade completed) (Give kind of work done during most of w Elementary/Secondary (0-12) College (1-4or 5+)	rorking	
	ed withir	Co	12 HOMEMAKER		OWN HOME
nd	be filed ntal Hygi ed other event,	Be	17. Father's Name (First, Middle, Last)  18. Mother's N	ame (First, Middle, Mai	den Sumame)
Maryland	2 should be filed within and Mental Hygiene. Ie marked other then eumatic event, Ite M	မှ	WILLIAM CLIFFORD MARSH MARY		
Jar	s 1 and 2 should f Health and Men item 27 le marke other treumatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or		
	ss 1 and of Health item 27			_	JRG, MD 20664
OF	ges If ite or of		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State cemetery, crematory or other place)	Date 200	c. Location - City or Town, State
tim	t. Pa tmen tent:			20-05 RI	VERDALE, MD
Baltimore,	permit. Pages Department of Importent: If ij eny injury or c		21. Signature of Funeral Service Licensee MOO479 22. Name and Address of Facility RAYMOND FUNERA	T. SERVICE	5 B A
	401 0 G		23a. Part1. Enter the disease, or complicitly is that caused the death. Do not enter the mode of dying, such as card	LAND 206	Approximate
8760,	Physician /Medical Examiner /Medical Examiner / Medical Examiner / Medical Physician and Physician and Physician and Physician (Medical Physician	Ical Examiner	Immediate Cause (Finat disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Head injuries complicating mening:  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	tis and en	cephatitis
P.O. Box 68	death certific e attending pl id for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
	requires that the een signed by th nould be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to the cause of death?  21/2 No 3 Probably 4 Unknown
Vital Records,	elaw hasb je 2 st	Completed		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
a	i <b>clen</b> : Th certificate rector, pag	o C	25. Was case referred to medical 26. Place of D	1 XYes 2	No 1 ✓ Yes 2 ☐ No
	Physiclen: this certific ral director,	OB	examiner?	eath (Check only one) Home 5 TResidence	
of			A	28d. Describe how i	
Division		Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  5-17-05  28b. Time of 11 36 Work?  1 No  28c. Injury at Work?  1 No  28c. Injury at No  28c. Inju	subject for	ell down stairs
N S	Attendia r death. sctor: A by the fu	iffica	3 Suicide 6 Could not be date mined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Stree	t and Number or Rural Route Number,
Ö	al or s afte	Sert	building, etc. (Specify)  residence	#510. LaP	t and Number or Rural Route Number, tate) #1 Hickory Lane, Lata, Maryland
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ce, and due to the caus	e(s) and manner as stated
	To th within Fo th:	Me	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month, Day, Year)
	- 2 - 0		Joshan Greenher MD OCME	2443	V 10 2005
.^	P		30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)	MA	Y 18, 2005
	0			et Baltimor	e Maryland 21201
	Sta	te			
4	Registr		JUN 0 3 2005 32. Highstrar's Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 26 per verbal 8845 7-21-05 vt.

State of Maryland / Department of Health and Mental Hygiene

			For State of Ma State of Ma Registrar	•	Department of F Certificate of				
			Registrar  1. Decedent's Name (First, Middle, Last)		oorumoute or	Dodin	2. Date of Deat		3. Time of Peath
	Physicia /Medic		Kenneth R. Cox				MAY	07 20	005 1650M
	Examin		4a. Facility Name (If not institution, give street and number)	1	4b. City, Town, o	r Location of Death		4c. County of	1_
	Funeral		Memorial Hospital 5. Social Security Number 6. Sex 7. Age	(In yrs. last birt	thday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		OOT  Birthplace (State or Foreign Country)
	Director		214-32-6663 <sup>1</sup> 3 <sup>1</sup> 3 <sup>2</sup> □ F	71 \	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day) Feb. 11	<b>,</b> 1934	Maryland
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	n or Location				10d. Inside City Limits
	Maryl	tor	MD Caroline		Federa1	sburg			1 ☐ Yes 2 😨 No
	or 28s	Oirec	10e. Street and Number		10f. Zip Code	632		0g. Citizen of Wha	
	sath w	eral	613 Liberty Road  11 Marital Status 12. Was Decedent B	ever in U.S.				United 14. Race	American Indian,
36	within 72 hours atter death with the Maryland ane. than "natural, or items 23a or 28a-f show 'to Madigal Examinar must be natified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent E Armed Forces?  1 Yes 2 N If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cub		Rican, etc.)	Specify:	White, etc. White
(A)	2 hou	ted	15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of working	na	16b. Kind of Busin	ness/Industry
	ithln 7	mple	Elementary/Secondary (0-12) College (1-4or 5		iife. DO NOT use retire			Trucki	ng
d 23.	77 57 10 10 10 10 10 10 10 10 10 10 10 10 10	CO	12 17. Father's Name (First, Middle, Last)	11	anspor tacto	18. Mother's Name		Maiden Sumame)	
lan	uld ba f fental h rkad of tic eva	To Be Completed	Lloyd Wesley Cox			Sidney	Marie	Trice	
Mary	ges 1 and 2 should ba filed t of Health and Mental Hyg If item 27 Is markad othe or othar traumatic evant,		19a. Informant's Name/Relationship (Type, Print)  Kay Bee Cox/Spouse	19b.	Mailing Address (Street 13 Libert	y Road,	Federa	r, City or Town, St. 1sburg	ate, Zip Code) MD 21632
∩e,	ges 1 and of Health If item 27 or other tr	i á	20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of cemeter	f Disposition (Name of ry, crematory or other pla	ce)	ate	20c. Location - Ci	*
(C∩) altimor	Pan ant:		*4 ☐ Donation 5 ☐ Other (Specify)	Fast Ne	w Market Cemet				Market, MD
Bal	permit, Departr Imports any inji		21. Signature of Funeral Service Licensee  Middled 7. Estern		216 N. Ma:		deralsb	urg, MD	21632
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir Immediate Cause (Final	the death. Do r	not enter the mode of dyi	ng, such as cardiac c	r respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition	a consequence	vascular	Accid	ent		
	Examiner		Sequential / list conditions,	etasta	etic Pro	state (	Cavei	noma	
	sit	iner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence	oi).				
-	ficate be executad g physician and as the burial-transit	Examiner	that initiated events c.	a consequence	of):				
68760,	ysiciar ysiciar	edical E	d						
7 68	certifical	Medi	IF FEMALE:						× =-=
18 P	leath certifi attending I tor use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	ey .		23d. Date Month	
RO	that the de ed by the a detached	hysic	1 Yes 2 No 9 Unknown						
SS, P	Se Co	by	Part II. Other significant conditions contributing to death b	ut not resulting i	n the underlying cause gr	ven in Part I.	23e. Did to	\rangle	ute to the cause of death?  Probably 4  Unknown
	aw raquin Is been si 2 should l	ompieted	Obstructive	Uvepa	uthy		24a. Was a		are autopsy findings available or to completion of cause of
AH.	The law cate has page 2:	Com	aupentension				perfor		ath? ]Yes 2 No
Vita(	Physician: The this certificate al director, pag	Be	25. Was case referred to medical		utpatient 3 □ DOA Ot	26. Place of Death		ne) lence 6 □Other	(Empire)
of	g Physer this eral di	n: To	27. Manner of Death 28a. Date of Inju		Time of 28c, Inju			ow injury occurred	
ion	ending sath, or: Atu he fun	atio	2 Accident investigation	7 7 007)		Yes 2 □ No			
Division of Vital	or Att	Certification;	3 Suicide 6 Could not be 28e. Place of Inj 4 Homicide determined 28e. Place of Inj building, et	ury - At home, fa c. (Specify)	arm, street, factory, office		28f. Location (S City or Tow		or Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To tha Funeral Diractor: After this certifica completely filled in by the funeral director, to	edical Ce	29a. Certifier  (Check only 2 Medical Examiner: On the basis o	f examination ar	e, death occurred at the t	ime, date and place, opinion, death occurr	and due to the d red at the time, d	cause(s) and manr date and place, an	ner as stated. d due to the cause(s)
	o the otha omplet	Med	29b. Signature and title of certifier	xieG.	29c. Licen	se number		29d. Date signed (	Month, Day, Year)
	⊢ ≯ ⊢ ō		Muc Rhoom	AALL	Lim	D47232		051	09/2005
_			30. Name and address of pers in who completed cause of c	leath (Item 23a)	(Type, Print) Idlewild	Avenue	Easton	. MD 21	
		ate	Mary DeShields, M.D.  31. Date filed (Month Day, Year) 32. Redistr	ar's Signature	- 4			,	
	اد Regist		31. Date filed (Month, Day, Year) 2005 32. Registr	was st	Agozali)				

			1 - For State Registrar		aryland / Depa		lealth a			200	5	86	97
П	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Month		<sup>ay</sup> 2005		. Time of De	
	/Medic	al	Thelma Josephine  4a. Facility Name (If not institution, give			4b. City, Town, or	- Looption of			2005 lc. County of		1912	М
	Examin	ier	7401 Willow Road			Frederi		i Death	`	Frede			
	Funeral Director		207 07 7 772	7. Ag	e (In yrs. last birthday) <b>91</b> Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of Monto	of Birth h, Day, Yea ary 25,	<sup>r)</sup> 1914	9. Birthplace Country) <b>Pennsy</b>	(State or F <b>Lvania</b>	oreign
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation					10d.	Inside City I	Limits
	Maryl -f sho	ţō	Maryland Frederic	k	Frederic	:k						1 XYes 2	
	th the	Funeral Director	10e. Street and Number		J	10f. Zip Code			10g. C	Citizen of Wh	nat Country?	)	
	23a c	a	7401 Willow Road A	partment		21702				U	.S.A.		
	er de	une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Orig in, Mexican,	in? (Specify Yes o Puerto Rican, etc	or No-		- American I , White, etc.	ndian,	
336	urs aft	þ	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:	No	1 ☐ Yes 2 👿 No	Specify:			Specify:	Whit	:e	
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show the Modical Examinat must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece	dent's Usual Occup	ation during most	of working	16b.	Kind of Busi	iness/Indust	ry	
2	ne. han "	mple	Elementary/Secondary (0-12)	College (1-4or	ō+) life.	DO NOT use retired	1)	· · · · · · · · ·		0	n Home		
ณ	filed v Hygie other t		17. Father's Name (First, Middle, Last)			lomemaker	18. Mother	's Name (First, M	iddle, Maide			-	
an	should be Ind Mental Is marked o	To Be	Clyde Marlin Shoen	naker				a Belle					
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparantent of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at ance.	-	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailir	ng Address (Street					tate, Zip Cod	de)	57
<b>∑</b>	1 and 2 Health Iem 27 I		David Perry Chapir	/Son		Mountair						-	2
Baltimore,	Pages 1 nent of H ant: If Itel ury or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ F		20b. Place of Dispo cemetery, crei			Date -		Location - C	•		
<u>=</u>	permit. Page Department Important: If any injury o		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service Licens</li></ul>	_	Smithsbur							Maryl	and
Ba	permi Depa Impo any ir		P. Rivan ME	William		Keeney ar 106 East	nd Bas Churc	ford PA h St., F	Funer reder	al Hon ick, N	ne 1D 21	701	
Н			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o Immediate Cause (Final	ne cause on each li	ne.		g, such as c	cardiac or respirati	ory arrest,		Inte	proximate erval Betwee iset and Dea	
	Physician /Medical		disease or condition resulting in death)	Due to (or as	a consequence of):	/. D					- 1	0 46	(M)
P	Examiner			Due to (or as	a consequence or,								
	n ä	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causes, Lisease or injury	Due to (or as	a consequence of):								
	ecuted and -transi	Examiner	that initiated events resulting in death) Last	Due to /or on									
760,	ate be executed hysician and the burial-transit	cal E		Due to (or as	a consequence of);								
687	ficate physis the			d									
Вох	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Med	23b. was decedent pregnant	3c. If yes, outcome		∃Ectopic pregnancy				23d. Date	of delivery		
O. B	ed for	sicia	in the past 12 months? 1 □ Yes 2 ☑ No	4☐Pregnant a 9☐Unknown		Other (specify)			_	Month	h Day	y Yea	ır
<u>Ч</u>	d by the	Phy	9 ☐ Unknown  Part II. Other significant conditions co		out not reculting in the u	adarhina anusa au	on in Part I	220	Did tobacco	use contrib	ute to the co	auco of doas	h2
ds,	Physician: The law requires that the der this certificate has been signed by the a ral director, page 2 should be detached to	d by	Faith. Other significant conditions co	ithouting to death t	at not resulting in the a	rideriying cause givi	en ni rait i.			2 <b>4</b> No 3			
Records,	w require been si should i	Completed						24a	Was an	24b. We	ere autopsy	findings ava	alable
	The law te has age 2 s	dwo	-						autopsy performed?	pride	or to comple ath?	tion of caus	e of
Division of Vital	ysician: The	0	25. Was case referred to medical				26. Place	of Death (Check of		10 1 L	JIES ZLA	PNO	
× ×	Physic this ce al direc	To B	I Tes ZENO	fospital: 1   Inpatie		- Laster	4 🗀 NUF	sing Home 5 🕾	Residence	6 ☐Other	(Specify)		
o u c	tending Ph leath. tor: After th the funeral	inol	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time o	Worl	yat k? Yes 2 □ N		ribe how inj	ury occurred	t		
S	or Attending after death. Director: After in by the fune	licat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Ini	ury - At home, farm, str		res ZUN		ion (Street a	and Number	or Rural Ro	ute Number	
<u>≥</u>	i i it o	Certification:	4 Homicide determined	building, et	c. (Specity)	oot, radiory, ormoo			r Tòwn, Sta				
	To the Hospital within 24 hours a To the Funeral Completely filled	dical C	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best	of my knowledge, deatl	h occurred at the tin	ne, date and	place, and due to	the cause(	s) and mann	ner as stated	d.	
	the Hin 24 the Ft		one)	and manner st	f examination and/or in ated.			occurred at the t					
ŀ	To To	Σ	29b. Signature and title of certifie			29c. License		2		ate signed (			
			20 Name and address of a second		In D		3191	_		May 20	), 20	US	
			30. Name and address of person who co		156 / OP	enny Vos (VV)	7136 (1)	PME	FREN	EMICL	1 ms	217	02
	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature		-0-010		- 1/	1 **	1		
	Registr	ar	MAY 2 0	בטטי	me A 1	Sagriff 1							

DHMH 17 Rev 1/2001

				eartment of Health and Mertificate of Death		ene. U U	5 18698
П	Dhusisi		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Y	3. Time of Death
	Physici /Medic		Virginia Lee Crislip				005 6:46P M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of	
			12760 KnifeBox Road	Greensboro		Caroli	ne
	Funeral		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	'ear)	Birthplace (State or Foreign Country)
	Director		236-46-9743 The Parish Table 1		July 24	1931 W	est Virginia
	land ow		10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits
	Mary Firsh	to	Maryland Caroline Greensbo	ro			1 ☐ Yes 2X No
	r 28e	Director	10e. Street and Number	10f. Zip Code	100	. Citizen of Wha	at Country?
	death with the Maryland ms 23a or 28a-f show rmust be notified at		12760 KnifeBox Road	21639		USA	
	be filed within 72 hours after death with the Marylar tal Hygliene. Id other than "natural", or Items 23a or 28a-1 show event, the Macileat Evaninat must be notilised at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No-		American Indian, White, etc.
õ	hours after tural', or ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	1 ☐ Yes 2 ☑ No Specify:			White
ğ	ural',	d by	3 X Widowed 4 □ Divorced Year or Dates:				
9500-61212	"nat	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired)	ng 16	b. Kind of Busin	ness/Industry
7	withir ane. than	E C	Elementary/Secondary (0-12)   College (1-4or 5+)	emaker		Own Ho	ime
	filed Hygid thar	CO	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma		·····
a		To B	Glenn Stanley	Letha Ta	nner	,	
Maryland	2 should be filed within 72 h and Mental Hygiene. Is marked other then "natu raumatic evant, the Medical	-		ling Address (Street and Number or Rura		City or Town, Sta	ite, Zip Code)
	is 1 and 2 should of Health and Mer itam 27 is marke other traumatic		Connie Reza/ daughter 127	60 KnifeBox Road G	reensbord	, MD 21	639
ē.	ss 1 a		20a. Method of Disposition 20b. Place of Disposition cemetery, or	position (Name of Dematory or other place)	ate 20	c. Location - Cit	y or Town, State
Ē	Page nent c int: If		M Bunal 2 Cremation 3 Hemoval from State	Shore Vet Cm 5/16,	/05 Hu	ırlock,	Maryland
Baltimore,	permit. Pages Department of I Important: If ite any Injury or of			22. Name and Address of Facility leggle and Helfenbe 0 Box 160 Greensbot	in Euner	al <sub>o</sub> Home	, PA
			23a. Part1. Enter the disease, or complications that daused the death. Do not exched, or heart failure. List only one cause on each line.				Approximate
	11 - 2 - 2 - 2 - 2			ancer	, , , , , , , , , , , , , , , , , , , ,		Interval Between Onset and Death
	Pnysician /Medical		disease or condition a.				1900
	Examiner		Due to (or as a consequence of):	KTIVE PULMANTI	dese	- 2/6	107001
		ner	Sequentially list conditions, if any, leading to immediate b.	- 110 - pormants			, , , , , ,
	uted d ansit	ᄪ	dry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
<u>_</u>	be executed ician and burial-transit	Exam	resulting in death) Last Due to (or as a consequence of):				
04/8	icate be executed physician and s the burial-transit	dicai	d				
õ	death certificate e attending phys d for use as the	led					
X Q Q	eath certific attending p	hysician/Me	IF FEMALE: 23b. Was decedent pregnant 1	□Ectopic pregnancy		23d. Date o	
-	s dea he att ed fo	sici	1 Yes 2 No	Other (specify)		Month	Day Year
J.	w requires that the de been signed by the should be detached	Phy	9 🗆 Onknown		1		
Ś	requires that een signed b nould be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			te to the cause of death?
cords	sen s nould	ted			1 Yes	2 □ No 3 Ø	Probably 4 Unknown
ပ်	2 2 3	ompleted			24a. Was an autopsy	prio	e autopsy findings available r to completion of cause of
=	The ate	S			performe 1 ☐ Yes 2 5		th? Yes 2□ No
Vital	ysician: This certificate	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
_	si d	2	1 ☐ Yes 2 KNo Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		ne 5 🗸 esidend		Specify)
	ling f	lo	27. Manner ol Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day Year)  28b. Time Injury	Work?	8d. Describe how	injury occurred	
<u>s</u>	ttand death stor:	lcat	2 Accident investigation 3 Suicide 6 Could not be 280 Blace of Injury At home form a	M 1 Yes 2 No	191 Logation (Street	at and Alumbar	or Rural Route Number,
UIVISION	or A after Dirac in by	ertification:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, ractory, office	City or Town, S	State)	or nurar noute (vumber,
	prital ours and maral filled	O	29a. Certifier 16 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, a	nd due to the caus	e(s) and manne	ar as stated
	To the Hospital or Attanding Ph within 24 hours after death. To tha Funarel Director: After th completely filled in by the funeral	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurre	ed at the time, date	and place, and	due to the cause(s)
	ro th Vithin Fo th	Me	29b. Signature and title of certifier	29c. License number	29d		fonth, Day, Year)
	. 2 - 0		value Mo	0205/132		5-13-	05
			30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)			
		1	Jome Alorean 598 Cynwood Dri	ve Suite 104 F	aston	MD Z	1601
	Sta		31. Date Ned (Month, Day, Year) 32. Registrar's Signature	1			
	Registr		31. Date filed (Month, Day, Year)  MAY 1 7 2065  32. Registrar's Signature				
O1 19	MH 17 Pay 1/20						

DHMH 17 Rev 1/2001

Physici	an	Decedent's Nan									<ol><li>Date of Month</li></ol>	Da	ıy	Year	3. Time of Deat
/Media			lm Eugene								May 20	, 2005	0		0859 A
Examir	ner	4a. Facility Name 11208	(If not institution  Cristine			ber)		4b. City, Town,	or Location of	of Death		40		of Death	m
Funeral Director		5. Social Security <b>214-90-33</b>		6. Sex	<b>k</b> µ 2□F 7.	. Age (In yrs	last birthday) Yrs.	Months Days		Min.	8. Date of (Month, Sept.	Birth Day, Year <b>29, 19</b>	74	9. Birth Cou Marcy	
*		Usual Residence	of Decedent 10b. County	у		10c. City	y, Town or Lo	ocation							10d. Inside City Lin
28e-f show	ō	Maryland	Washin	ahan		Hao	enstown								1 □ Yes 2 🙀
1289	Director	10e. Street and N		<del></del>				10f. Zip Code				10g. Ci	tizen of \	What Cou	ntry?
23a o	ai D	11208	Cristins	s Circ	de			217	42			Unit	bed S	tates	
yes large solution and Mental Hygiene. If itam 27 is marked other than "netural", or Itema 23a or 28e-f show or other traumatic avant, the Medical Examinar must be netified.	by Funeral	^	rried 2 Mar	rried	2. Was Deced Armed Forc 1 ☐ Yes 2 If Yes, Give Year or Date	es? !⊋No		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☐ No	ban, Mexicar	n, Puerto F	cify Yes or Rican, etc.)	No-		ck, White,	can Indexe, etc.
netu dira	Completed	(Spe	15. Deceder ecify only highe				(Give	dent's Usual Occi kind of work don DO NOT use retir	e during mos	t of workin	g	16b. K	(ind of B	usiness/In	ndustry
than	dmo	Elementary/Sec 12	ondary (0-12)		College (1-4	4or 5+)	ļ	S Represe	,			ī	Distr	ibutor	•
Hygi othar ant,		17. Father's Name	(First, Middle,	, Last)					1	er's Name	(First, Mid	dle, Maider			
h and Mental Hygiene. 7 ia markad othar than "Iraumatic avant, tre Mac	To Be	Malco	lm Eugene	e Chap	omain.				Betty	y Jean	Runbu	rg			
and N a mar	-	19a. Informant's	Name/Relations	ship (Typ	e, Print)		19b. Maili	ng Address (Stree	and Number	er or Rurai	Route Nu	mber, City	or Town,	State, Zij	Code)
of Health of Health of Itam 27 i		Krist	y M. Kolp	pack/	Fiance			3 Cristins	Circle,	Hage	cstown	, MD 2	1442		
nent of He int: if itan		20a. Method of Di 1 Burial 2 1 Donation	,	3 □R6	emoval from St		emetery, crei	osition (Name of matory or other pl			ate <b>, 200</b> 5			,	own, State
Department Important: Important: fan any injury o		21. Signature				, /	2	2. Name and Add	ess of Facilit	y Doug	las A.	Fiery	Fure	wn, Mi ral Ho	
105 2 2		1	- 1(1/)	11/0	0 1 1 1 71	1110111	1	1994	TOII	M D	arrana h	Tun. M	) 217	42	
hysician /Medical		23a. Part1. Enter shock, or he Immediate Cause disease or condit resulting in death	art failure. Lis (Final ion	or complicationly one	Hyper:	ch line. <b>tensiv</b> e	h. Do not en	1331 Easte ter the mode of dy rosclero	ing, such as	cardiac or	respirator	y arrest,			
/Medical xaminer	i Examiner	shock, or he Immediate Cause disease or condit	art failure. List (Final ion ) conditions, immediate derlying or injury ts	pr complice st only one	Hyper  Due to (or	ch line.	h. Do not end e Athe uence of):	ter the mode of dy	ing, such as	cardiac or	respirator	y arrest,			Interval Between
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registre Certificate of Death Rag. No. 2. Date of Death Decedent's Name (First, Middle, Last) Day Year **Physician** Virginia Chappell MAY 24, 2005 11:09A /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) 6. 1916 Memorial Hospital Allegany Cumberland 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1 M 2 XF MD Yrs 217-10-4419 88 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23s or 28e-f show 10c. City, Town or Location 10b. County 10a State 10d. Inside City Limits is 23s or 28e-f show Allegany MD Cresaptown Completed by Funeral Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14916 Winchester Road 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) other traumatic event, the Madical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Albert George Shank Annie Virginia (Wright) Shank 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jackie Fletcher daughter 13218 5th Avenue MD 21502 Cresaptown t of Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State ö Department fimportant: If any injury or once. Sunset Memorial Park 5/27/2005 Cumberland MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 23a Fart | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 108 Virginia Avenue; Cumberland, MD 21502 Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiac arrest 30 minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** cute myocardial infarction 30 minutes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Due to (or as a consequence of) by Physician/Medical Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. the IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 menths? 1 ☐ Yes 2 Ø No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 No 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Thomicide within 24 hours a To the Funarel C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 29c. License number MAY 26 2005 D14865 aur

State Registrar

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Robustiano Barrera M.D.
31. Date filed (Month, Day, Year) 32. Paistrar's Signatu

2005 ני 0 אשנ

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Mem. Hosp Med Bldg Cumberland MD 21502

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 11:05 AM 2005 ear **Physician** Anthony Peter DiGioia 24՝ /Medical 4c. County of Death 4b. City. Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) Examiner Westernport Allegany Moran Manor Nursing **Home** If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 217-05-0276 XXM 2□ F 88 Yrs May 5, 1917 Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" any injury or other traumatic excessions. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a Stete 1 ☐ Yes 2 Ho MD. Allegany Westernport Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 22508 21562 United States Horserock Road 12. Was Decedent Ever in U,S.
Armed Forces?

\*\*TCXYes 2 \sum No WW 2
If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status white 1 Never Merried 27 Married 1 ☐ Yes 22 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life\_DQ NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Paper Manufacturer Elementery/Secondary (0-12) UNKNOWN College (1-4or 5+) Welder 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Carlo DiGioia Josephine Cantarone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 22508 Horserock Road, Westernport, Maryland 21562 Amelia DiGioia/ wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 05/27/ 2005 ₩ Burial 2 Cremation 3 Removal from State Oakland, Maryland Garrett Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Boal Funeral Home 111 Church St., Westernport, Maryland 21562 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Endstrye months Examiner Due to (or es a consequence of): Physician/Medical Examiner ate has been signed by the attanding physician and paga 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 A 100 1 ☐ Yes 2 ☐ No this certificate r: After this certifical e funeral director, p 26. Place of Death (Check only one) 8 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 printing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 28c. Injury at Work? 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 1 La Natural 5 Pending s aftar death.

I Director: After in by the fundamental in the fundame 2 🗆 No investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide To the Hospital o within 24 hours at To the Funeral D complataly filled i refifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 921244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Jesus Tan, Frostburg Plaza, Frostburg, Maryland 21532

State Registrar 31. Dete filed (Month, Day, Yeer)
MAY 2 5 2005

32. Registrer's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Month 4:00 P 21 2005 Day May /Medical 4c. County of Death
Frederick 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sunrise Assisted Living Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🙀 F 90 214-03-9055 Yrs Director Sept.19,1914 Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State or 28a-f show ir than "natural", or items 23a or 28a-f shov The Waddowl Examination is the contilled at 1 Tyes 2X No Jefferson Director Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21755 USA 4656 Newington Road filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: White þ Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Beautician Hair Care other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any link or other treumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 01and Mamie Grubb Charles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4656 Newington Road, Jefferson, MD 21755 Edward Day/Son 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■Burial 2 □ Cremation 3 □ Removal from State Mt. Olivet Cem. May 24,2005 Frederick, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part Effective the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on a list time. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End Stage Dementia yrs /Medical Due to (or as a consequence of) Examiner Parkinson Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events VIS Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Hypertension yrs attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2X No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Depression, Peripheral Vascular Disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? Mitral Valve Insufficiency 24a. Was an autopsy perform 2∏ No XXNo 1 Yes 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify Assisted 1 ☐ Yes 2 🗷 No Certification; To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 ANatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and talle of pertifier D54749 May 23, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Allen Reilly, MD 801 Frederick, MD 21701 31. Date filed (Month, Day, Year) MAY 2 3 2005 32 Aegistrar's Signature State Registrar

DHMH 17 Rev 1/2001

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П	Physici	an	Decedent's Name (First, Middle,	Last)						te of Deat	Day	Year	3. Time of Death
	/Medic	al	Edna Ma 4a. Facility Name (If not institution,	e Davis	ar)		4b. City, Town, or	Logation o	Ma	ı <u>y</u> 1	7 20 4c. County	05	2:00 A <sup>M</sup>
	Examin	er	Ruxton Health		•		Dentor		n Death			oli	ne
	Funeral			S. Sex 7.	Age (In yrs. last bin	thday)	If Under 1 Year	If Under 2	24 Hrs. 8. Da	e of Birth onth, Day,			place (State or Foreign
	Director		220-01-7773	1 ☐ M 2 💢 F	86	Yrs.	Months Days	Hours	Min. Janu	ary 18	1919	Mar	yland
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Lo	cation						Od. Inside City Limits
	Maryl -f aho	tor	Maryland Car	roline	Pre	est	on						1 ☐ Yes 2 ☐ No
	h the	Directo	10e. Street and Number				10f. Zip Code			_1	0g. Citizen of V	Vhat Cour	ntry?
	23a c		3125 Choptank	Road			2165	5		U	nited	Sta	tes of America
	tems	Funeral	11. Marital Status	12. Was Decede Armed Force	s?	13. \	Vas Decedent of Hi f Yes, specify Cuba		gin? (Specify Ye , Puerto Rican,	s or No- etc.)		e - Americ	can Indian,
36	rs afte		1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 1 If Yes, Give Year or Date	_		I□Yes 2□MAvo	Specify:			Specify		
00	72 hours after death with the Maryland hatural', or Items 23a or 28a-f ahow dical Exactions the mollified at	Completed by	15. Decedent's	Education		Deced	lent's Usual Occupa	ation			16b. Kind of Bu		asian <sub>dustry</sub>
215	within 7 iene. 'than "n	ple	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-40		(Give life. I	kind of work done a DO NOT use retired,	turing most )	of working				ŕ
21	filed wi Hygien othar th	Con	7			H	omemake					Iome	
Maryland 21215-0036		Be	17. Father's Name (First, Middle, La					18. Mother	r's Name (First,			•	
ž	2 should be and Mental is markad aumatic ev	은	Everet  19a. Informant's Name/Relationship	t Passwa <sup>*</sup>	ters	Mailin	n Address /Street	and Number	roc Rusal Route	Number	Lyder	State Zin	<sup>Code)</sup> 21655
	and 2 s lealth an m 27 is har trau		Pauline Coulb		ughter	21	25 Chart	tank	Dood	Dro	city of rown,	Jidie, Zip	21655
Ē,	s 1 ar of Hea itam otha		20a. Method of Disposition		20b. Place of	Dispo	25 Chopt sition (Name of natory or other place		Date	PIE	20c. Location -	City or To	y I d II Q own, State
E	Pages nent of I ant: If its ary or o		1 ☑ Burial 2 ☐ Cremation 3  '4 ☐ Donation 5 ☐ Other (Spe				Cemete:		/20/20	05	Dentor	n, M	aryland
Baltimore,	permit. Pages 1 and Department of Heall Important: If itam 2 any injury or other once.		21. Signature of Funeral Service Li	no Mou		22 M	Name and Addres	s of Facility	1 Home	, P.	A. Dent	ton.	21629 Maryland
Г			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caus	ed the death. Do n	not ente	er the mode of dying	g, such as o	cardiac or respir	atory arre	est,		Approximate Interval Between
	Pnysician	l n	Immediate Cause (Final disease or condition		richem	W.	Cand	Dmu	opulh	,			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of	of):			Jan-	-			TIGECL
В	LAdiffilie	_	Sequentially list conditions,	b	as a consequence o	-6).							
	rted	nine	Sequentially list conditions, if any, leading to immediate cause. Enter undarrying Cause (Disease or injury	Due to (or s	as a consequence o	JI J.							
<u>,</u>	execun and and ial-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequence of	of):						_	
8760,	ate be executed thysician and the burial-transit	dicali		d									
9	tiffic as	Medi	IF FEMALE:								1		
Вох	that the death certific ed by the attending p detached for use as	by Physician/Med	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		Ectopic pregnancy				23d. Date Mor	e of delive	ny Day Year
0	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant 9☐Unknown	at time of death	5 🗀	Other (specify)				10101		Day Tour
<u>α</u>	res that the signed by th be detache	/ Ph	Part II. Other significant condition	s contributing to death	but not resulting in	the ur	iderlying cause give	in in Part I.	23	e. Did tob	acco use contr	ibute to th	e cause of death?
rds,	requires neen sign hould be	d b								1 ☐ Ye	s 2√2 No	3 🗌 Prob	abiy 4 🗀 Unknown
Division of Vital Record	aw requir as been si 2 should	Completed							24	a. Was an	1 24b. V	Vere auto	psy findings available
Re		Шо							_	autopsy perform Yes 2	ed2/d	eath?	npletion of cause of 2 No
ital		Bec	25. Was case referred to medical examiner?					26. Place	of Death (Checi				20110
of V	Physician: r this certific ral director,	ျ	1 ☐ Yes 2 ☑ No		tient 2 ER/Out			Nur	sing Home 5[				)
o uc	nding P Ith. :: After e funera	lon	27. Manner of Death 1: □ Natural 5 □ Pending			ime of njury	28c. Injury Work	?		scribe ho	w injury occurre	∍d	
isic	or Attanding after death. Diractor: After in by the funer	licat	2 Accident investigat 3 Suicide 6 Could no	be ass Blace of	njury - At home, far	rm stre		∕es 2□N		ation (Str.	eet and Numbe	er or Rura	I Route Number,
<u>&gt;</u>	after after Dirac	Certification;	4 Homicide determine	building,	etc. (Specify)	m, our	ot, la diory, dilico		City	or Town,	State)	n or ridra	THOUSE HUMBER,
	To the Hospital or Attanding Phwithin 24 hours after death. To the Funaral Diractor: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one)	Physicien: To the be teminer: On the basis and manner	of examination and	, death	occurred at the tim estigation, in my op	e, date and inion, death	d place, and due h occurred at the	to the ca e time, da	use(s) and mar te and place, a	ner as st nd due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. License	number		29	d. Date signed	(Month, I	Day, Year)
			1 Rikidray	MD			Do	0616	588		0511	7/05	_
			30. Name and address of person wh	no completed cause o	death (Item 23a) (	Туре, і			- 9 3			, - 3	
			2108 Di Donate		Chesto			1					
	Sta Registr		31. Date filed (Month, Day, Year)	2005 32. Reg	strar's Signature		Coast o						
				- War	Caronina Span	and the same	E / Car - Ca						

			For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of F rtificate of I			iene 19. No. 2 N	n E	10701
			Decedent's Name (First, Middle, Las.	t)				2. Date of Death Month	h Day	Year	3. Time of Death
	Physicia /Medic		PAMELA JEAN CLAR	KE DOVE				MAY		005	3:06 A <sup>M</sup>
ř	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	r Location of Death		4c. County		
			22H QUEEN VICTOR			CHESTEI		15:0	QUEEN		
	Funeral		5. Social Security Number 6. Se	x 7. Age □M 2 <b>X</b> F	(In yrs. last birthday)  71. Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, FEB. 18	Year)	9. Birthplac Country	e (State or Foreign
	Director		329-26-0496 Usual Residence of Decedent		74 Yrs.			FED. 10	, 1931	111	
	land ow		10a. State 10b. County		10c. City, Town or Lo	cation				10d	. Inside City Limits
	Many	to	MD QUEEN AN	NE'S	CHESTER						1 Yes 2 No
	th the	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of W	hat Country	?
	23a c		22H QUEEN VICTOR	IA WAY		21619			USA		
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland i Health and Mental Hygiene. Item 27 is marked other than "natural", or Itama 23s or 28s-f show other traumatic event, Itis Medical Examina, must be myilled at	by Fur	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent if Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	Hican, etc.)	Specity:		re
2-0	72 hc	etec	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usual Occup	during most of worki	ng	16b. Kind of Bu	siness/Indus	stry
21	han han	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+) TEAC	DO NOT use retired	3)		EDUCAT	TON	
2	Hygie ther t		12 17. Father's Name (First, Middle, Last)	<u> </u>	IEAC	нек	18. Mother's Name	(First, Middle, N			
au	d be ontal l	o Be	WILLIAM JOSEPH C	LARKE			RUTH CAL	RTER			
<u></u>	Shoul of Me mark	၉	19a. Informant's Name/Relationship (7		19b. Mailir	ng Address (Street	and Number or Rura		City or Town,	State, Zip Co	ode)
	nd 2 alth a 27 is r trau		THOMAS LELAND DO	VE/HUSBAND	22Н	QUEEN VIO	CTORIA WAY	, CHEST	ER, MD	21619	)
Baltimore,	ages 1 a ant of Hea it: if item y or othe	1	20a. Method of Disposition 1 □ Burial 2 ▼Cremation 3 □ * 4 □ Donation 5 □ Other (Specify	Removal from State	20b. Place of Dispo	KE CREMA	PTON	/2005	STEVEN:	,	
Baltir	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service Licens		Д. 22 <b>F</b>	ELLOWS, I	ss of Facility HELFENBEIN	& NEWN	AM FUNE	RAL HO	
			23a. Part 1. Enter the disease, or comp	plications hat caused			OCK ROAD,				pproximate
	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition		NCER					Ö	iterval Between
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):						
Ġ.	\$.	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Oue to (or as :	a consequence of):						
	outed ansit	Examine	Cause (Disease or injury that initiated events	С.							
o,	be executed sician and burial-transit	Ex	resulting in death) Last	Due to (or as	a consequence of):						
8760,	physic the bu	dical		d		·					
O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 28 No 9 □ Unknown	23c. If yes, outcome 1⊟Live birth 4⊟Pregnant at 9⊟ Unknown	2 Fetal death 3	Ectopic pregnancy	1		23d. Date Mor	e of delivery oth Da	ay Year
٩	uires that t i signed by id be detac	þ	Part II. Other significant conditions co	ontributing to death b	ut not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	2.		cause of death? ly 4 Unknown
Records,	The law require are has been sin page 2 should t	Completed						24a. Was ar autops perform 1 Yes 2	y ned? d	rior to comp eath?	y findings available letion of cause of
Vital		Be C	25. Was case referred to medical examiner?				26. Place of Death	(Check only one	θ)		
>	1 <b>y</b> 8	10	1 Yes 2 Dio	Hospital: 1 ☐ Inpatie	1		er: 4 Nursing Ho				
n of		on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	ry 28b. Time o y Year) Injury	Wor	k?	28d. Describe ho	w injury occurre	ed	
Sio	leat lor: the	cat	2 Accident investigation 3 Suicide 6 Could not be		At home form at		Yes 2 □ No	28f. Location (Sti	reat and Numbe	ar or Rural F	Toute Number
Division	al or At s after d al Direct od in by	Certification:	4 Homicide determined	building, etc	ury - At home, farm, str c. (Specify)	reet, factory, office		City or Town		or moral r	obto (valibo),
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Medical (	29a. Certifier Cortifying Ph	ysician: To the best on the basis of and manner sta	of my knowledge, deat examination and/or in ated.	h occurred at the tir vestigation, in my o	me, date and place, appinion, death occurr	and due to the ca ed at the time, da	ause(s) and mar ate and place, a	nner as state and due to th	ed. e cause(s)
	To the Within To the	Me	29b. Signature and title of certifie	1		29c. Licens	e number	29	9d. Date signed	(Month, Da	y, Year)
( I	2)		30. Hame and address person who	completed cause of d	eath (Item 23a) (Type,		10 110	M \ 22000	15 m	18	101
	1,0		STANLEY WR	YTKINS W	2 3/00	19637616	1000	INTYTUL	12 M	( 1	7 - )
	Sta Registi		31. Date filed (Month, Day, Year)  MAY 1 9 21		ar's Signature	DOLLARY A					

DHMH 17 Rev 1/2001

			1 - For State of Maryla		artment of H			iene eg. No()	5 10705
Н	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Deat	23 <sup>Day</sup> 200	3. Time of Death
	/Medic Examin		Mary Lou Dowell  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	r Location of Death		4c. County of I	2.50 P
	LAdillill	CI.	1037 Bishop Walsh Rd		Cumber	land		Allega	
	Funeral Director		557-24-8415 ¹□M ⅔F 84	i. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day May	7 <sup>Yea</sup> (921	Birthplace (State or Foreign Country) Colorado
	land bw		Usual Residence of Decedent  10a. State 10b. County 10c. C	ity, Town or Lo	cation	<del></del>			10d. Inside City Limits
	Mary 9-1 sh	tor	MD Allegany Cu	mberla	.nd				1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of Wha	t Country?
	eath v	Funeral	1037 Bishop Walsh Rd  11. Marital Status 12. Was Decedent Ever in	US 13 V	21502		ecify Yes or No-	USA 14 Bace -	American Indian.
39	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 271s marked other then "neturel; or Iteme 23a or 28e-1 show or other traumatic event, Its Modical Examitrational by routified at	by Fun	Armed Forces?  1 Never Married 2 Married  1 Yes 2 No If Yes, Give Year or Dates:	If	f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		White, etc. White
2-0	72 hou		15. Decedent's Education (Specify only highest grade completed)		tent's Usual Occupa	ation during most of work	ina	16b. Kind of Busin	ess/Industry
12	within ene. then "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. [	oo Not use retired omemaker	3)	9	TT	
9	filed v Hygie other i	e Co	17. Father's Name (First, Middle, Last)	.110	Julemaker	18. Mother's Name	e (First, Middle, M	Home Maiden Surname)	
<u>Ilan</u>	uld be Jental rked c	To B	Charles W. Harkness			Marguer	ite Luc	ola (Ki	tchens)
Maryland 21215-0036	ind 2 should alth and Men 27 Is marke ir traumatic		19a. Informant's Name/Relationship (Type, Print)  John Dowell Son			and Number or Run			. ,
Baltimore,	of He		A D Buriel OF Connection O Domestic Control	cemetery, cren	sition (Name of natory or other plac	(8) Marr		20c. Location - Cit	y or Town, State
ţi	t. Pages rtment of I rtent: If it		`4 □Donation 5 □ Other (Specify)		n Cremat	Ory 25.	2005	Uniont	own, PA
Bal	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service Licensee	n.	302 Nat	cional H	WY, LAV	VALE, M	ervice, PA 21502
	Pnysician		23a. Part 1. Enter the disease, or complications that daysed the dea shock-or heart failure. List only one cause on each lin	ith. Do not ente	er the mode of dyin	1	or respiratory arre		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a corse	quence of):		0	, 0 0,0		- XYES
-	p ii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	qизлов of):					
4	be executed ician and burial-transit	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	quence of):					
8760,	ficate be executed physician and ts the burial-transit		d						
9	certificate iding phys	Medi	IF FEMALE:						
. Box	atter for u	Physician/Medical	23b. Was decedent pregnant in the past 12 morths?  1 Vas 2 Mor	tal death 3	Ectopic pregnancy Other (specify)	·		23d. Date of Month	delivery Day Year
P.O	t the by th ache	Phys	9 ☐ Unknown			an in Donal	02a Did tak		and the second of death?
ords,	w requires that been signed I should be det	þ	Part II. Other significant conditions contributing to death but not re	suiting in the un		еп іп Рап І.			te to the cause of death?  Probably 4 Dunknown
Vital Record	e la has	Completed					24a. Was a autops perform	y prior deat	e autopsy findings available to completion of cause of h? Yes 2 \(\sum \) No
/ita	Physicien: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?		0.5	26. Place of Deatl	h (Check only on	θ)	
of	Phys rthis ral dii	To To	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☑  27. Manner eath 28a. Date of Injury	ER/Outpatient		4   Industry Ho		ence 6 Other (	Specify)
	Attending I r death. ector: After by the funer	itlon	1 La atural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	Work	k? Yes 2 □ No	200. Describe 110	w injury occurred	
Division	o Hospitel or Attendi 24 hours after death, Funerel Director: A etely filled in by the f	ertificátion:	3 Suicide 6 Could not be determined 28e. Place of Injury - At I building, etc. (Spec	nome, farm, stre	eet, factory, office		28f. Location (St. City or Town		r Rural Route Number,
	To the Hospitel or Al within 24 hours after & To the Funerel Direc completely filled in by	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my kn (check only one)  1 Medical Examiner: On the basis of examinand manner stated.	owledge, death ation and/or inv	occurred at the time vestigation, in my op	ne, date and place, pinion, death occurr	and due to the cared at the time, da	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of confifier	100-0	29c. License	number	21	9d. Date signed (M	Ionth, Day, Year)
	8		30. Name and address of person who completed sause of death (lte Dr. Gary Wagoner, 925 Bi			pad, Cum	horles	U) o	4 y - U - V
	Sta Registr		31. Date filed (Month, Day, Year)  JUN 0 3 2005  32. pegistrar's Sign	aturo		Jaa, Cull	MET TAU	a, ™D Z	1302
			7-0-0-						

50	.10						e ink. Ensure	•		
			1 - For Amend Item 4c8 Registrar	Unpend Ite	23a,	ertifica	7,28a-f per e of Death	me 6844 <sup>y</sup>	6-6-05 tas	18706
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death
	/Media		Charles Glen Evans					May 26.	, 2005	2:42 a. M
	Examir	er	4a. Facility Name (If not institution, give substitution, give substitution). University Hospita		ek Traun		Town, or Location of Dea Itimore City		4c. County of Death	1
-	Funeral		5. Social Security Number 6. Sex		In yrs. last birth	day) If Unde	r 1 Year   If Under 24 Hi	s. 8. Date of Birth	9. Birth	place (State or Foreign
	Director			M 2□F	26 Y	Months	Days Hours Min	Oct. 31	r, Year) Cou	place (State or Foreign intry) ISY1vania
	D ≥		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town	r Loopting				
	Aaryla Fehov	ō								10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	28a-	Director	Maryland Washingto	<u> </u>	Hagerst		Code	1	10g. Citizen of What Co	
	h with		11214 Cristins Cir	cle			21742	_	United Stat	
	ems a	Funeral		12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Dece	dent of Hispanic Origin?			ican Indian,
36	s after, or It	by Fu	1 № Never Married 2 Married	1 ☐ Yes 2 🔯 No If Yes, Give		1 ☐ Yes		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		hite
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. Ather than "natural", or Items 23a or 28a-1 ehow ant, the Medical Exertiret must be rodified at		3 Widowed 4 Divorced	Year or Dates:	16а Г	ecedent's Usu	al Occupation		16b. Kind of Business/l	
212	nin 72 In "na Medic	Completed	(Specify only highest grade			Give kind of we fe. DO NOT L	al Occupation ork done during most of w ise retired)	orking	Tob. Table of Desirioss	idustry
21	d with giene er the	Com	Elementary/Secondary (0-12)	College (1-401 3+)		eiving	/Stock Clerk	<u> </u>	Retail	
nd	be file d oth event	Be	17. Father's Name (First, Middle, Last)	Tee				ame (First, Middle, I	Maiden Sumame)	
$\frac{2}{3}$	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event. The Medical Examiner must be notified at	<sup>2</sup>	Charles Glen Evans		401.4			a Starr		
ā Z	d2st thanc 7 is n traun		19a. Informant's Name/Relationship (Ty.) Patricia Evans / M			-	S (Street and Number or F			
อ์	Heal Heal tem 2		20a. Method of Disposition		20b. Place of D		stins Circle		20c. Location - City or T	
E C	Pages ent of nt: If i		1 ABurial 2 ☐ Cremation 3 ☐ R  `4 ☐ Donation 5 ☐ Other (Specify)	iemovai mum state			Gardens		Frederick, 1	Maruland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau		21. Signature Juneral Sorvice License				nd Address of Facility Ven Funeral			
<u> </u>	89589		1/1/1/			9501 Ca	atoctin Mtn.	Hwy. Fre	ederick. MD	21701
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the cause on each line.	e death. Do no	enter the mod	de of dying, such as cardi	ac or respiratory arre	rest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Multiple :						Onset and Death
Ü.	Examiner			Due to (or as a c	consequence of	:				
		jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a c	consequence of	:				
	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Examiner	that initiated events	J						
760,	oe exe		resulting in death) Last	Due to (or as a c	consequence of	•				
687		dical		l		<del></del>				
×	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of	pregnancy				23d. Date of deliv	en/
Box	death e atter d for u	iclar	in the past 12 months?	1□Live birth 2 [ 4□Pregnant at tim		3 ☐ Ectopic p 5 ☐ Other (s)			Month	Day Year
P.O.	t the c by the	hys	9 Unknown	9□ Unknown						
	ires tha signed I be det	by P	Part II. Other significant conditions cor	tributing to death but r	not resulting in t	ne underlying	cause given in Part I.		bacco use contribute to	
ord	w requir been si should	ted	Seizure Disorder					1 □ Y€	es 2⊅No 3□Pro	bably 4 Unknown
ec S	ne faw n has b ge 2 st	Completed						24a. Was a autops	sy prior to co	opsy findings available ompletion of cause of
<u></u>								perform 1 Yes 2	2 □ No 1 △Yes	2□ No
Ħ	siciar certif irecto	o Be	25. Was case referred to medical examiner?  1X Yes 2 No	lospital:	2∏ED/Outo	atient 3 Do	Other	eath (Check only on		
ō	Attending Physician: The Ir death. ector: After this certificate ha by the funeral director, page	$\vdash$	27. Manner of Death	28a. Date of Injury	28h Tin	o of	28c, Injury at		ence 6 Other (Speci ow injury occurred	unk
lo	ath. rr: Aft	atlo	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Y 5-26-05	θαr) <b>Fou</b> 1:4	ја, м	Work? 1 ☐ Yes 2 <b>X</b> No			
Division of Vital Records,	200>	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, farm 'Specify)	, street, factor	y, office	28f. Location (St. City or Town	treet and Number or Rur n, State) $1170~ m{W}_{ullet}$	Patrick St.
	pital o		SOn Continue 1 Continue Bhu	Highway				Rte.40E,	Frederick,	MD
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ★ Medical Examis	ner: On the basis of ex and manner stated	camination and/	or investigation	at the time, date and place, in my opinion, death occ	curred at the time, da	ause(s) and manner as s ate and place, and due t	o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29	c. License number	25	9d. Date signed (Month,	
			> Caral H	allar	n ma	1	OCME		May 26, 20	)05
1	3		30. Name and address of person who co	mpleted cause of deat	th (Item 23a) (T	rpe, Print)	Penn Street	Baltimo	ore, Maryla	nd 21201
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 3 1	32. Registrar's 2005	Signature	. Soil				
			D101 11 4 m	666	Bank a new Section	The said of the sa				

For State Registrar

**Physician** 

/Medical

1. Decedent's Name (First, Middle, Last)

Donald

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Fogle

E lwood

2. Date of Death

May

26

2005 Year

3. Time of Death

9:35pm M

I	Examir	er	4a. Facility Name (If not institution, Glade Valley N	-			4b. City, Town	, or Location kersvi			4c. Count	y of Deal deri	
	Funeral Director				79 79	t birthday) Yrs.	If Under 1 Yes Months Day	ar If Unde	r 24 Hrs.	8. Date of Bi (Month, Di Oct 4	rth av. Year)	9. Bin	hplace (State or Foreign buntry)  Yland
	the Maryland 28a-f show notified at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Free	derick	10c. City,	Town or Lo	cation Union B	ridge					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	n with the 3a or 28a st be noti	al Direc	10e. Street and Number 11704 Coppermin	ne Road			10f. Zip Code	217	'91		10g. Citizen of	What Co	
336	permit. Pages 1 and 2 should ba filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinational Conditional and once.	by Funeral Director	11. Marital Status  1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?  1 TYes 2 If Yes, Give Year or Dates:	?	4-	Was Decedent of Yes, specify C			ecify Yes or No Rican, etc.)	o- 14. Ra Bla Speci	ck, Whit	nican Indian, e, etc. White
Maryland 21215-0036	thin 72 hou e. an "natura Medical E	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)			16a. Deced (Give life. L	dent's Usual Occ kind of work doi DO NOT use ret	ne during mo ired)	st of work	ing	16b. Kind of E		
nd 21	a filed wi al Hygien d other th	Be Con	17. Father's Name (First, Middle, I	•		FIIOL	ographe	18. Mot		e (First, Middle	redera	me)	vernment
aryla	should band Ment smarked	70	Archie  19a. Informant's Name/Relationsh		Togle	19b. Mailir	ng Address (Stre		ulah beror <i>R</i> un	al Route Numb	er, City or Town	Mai: , State, 2	
Ž,	and 2 Balth a n 27 Is		Mrs Sylvia Fog	Le/ Wife							Bridge		
Baltimore,	Pages 1 nent of He ant: If Iter ary or oth		20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp.				sition (Name of matory or other p n Mem Ga			31,200	20c. Location  5 Fred	•	Town, State k. Maryland
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service C	Dein Dein	M0076	06 1	Name and Ado Keeney 06 East	tress of Fac & Bas Churc	sford h St	P.A. F	uneral	Home larv1	and 21701
		(	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that cause only one cause on each l	d the death.	Do not ent	er the mode of o	lying, such a	s cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as	ere c	nce of):	a sou	lar	9	et rol	se		7 Days
V	cuted of ansit	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b Due to (or as	a conseque	nce of):							-
68760,	ate be exec hysician ar ihe burial-ti	lical Exa	resulting in death) Last	Due to (or as	a conseque	nce of):							
P.O. Box 68	ires that the death certificate be executed signed by the attending physician and doesched for use as the burial-transit	by Physiclan/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	eath 3	Ectopic pregnal					ate of del	ivery Day Year
ds, P	uires that signed by d be deta	d by Pr	Part II. Other significant condition		out not resulti	ing in the u	nderlying cause	given in Par	1.	23e. Did	,		the cause of death?

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas

JUN 0 3

31. Date filed (Month, Day, Year)

23d. Date of delivery Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiel 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatur and title of certifier Shah

BI State Registrar

Completed

Be

2

Certification:

Medical

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: After this funeral of

Director:

within 24 hours after To the Funeral Dire

DHMH 17 Rev 1/2001

To the Hospital or Attending Physician: The law requires th

Division of Vital Records.

	an	1. Decedent's Nam Stanley	e (First, Middle, L Groka								2. Date of Month		ή5 <sup>Υ</sup>	/ear	3. Time of Death 6:28 p.
Medio/ Examir		4a. Facility Name (	If not institution, gi	ive street and number	)			Fown, or Lo	ocation o		ray 1		. County of	Death	0:20 p.
		Atlantic					Ber1		/ Hadas (	A Hen I					County
uneral rector		5. Social Security N 214-46-04 Usual Residence of	115	Sex 7. A	58	ast birthday) Yrs.	Months		f Under 2 Hours	Min.	8. Date of Month, 04/01	/1947	7	Count	PA
show	_	10a. State 10b. County 10c. City, Town					ocation						10d. Inside City Limi 1 ☐ Yes 2		
28a-1 s polifie	Director	MD  10e. Street and Nu	Worcest	ter	Бе	rlin	10f. Zip 0	Cado				10a Cii	inne of 14th	-1 Court	
3a or	i D	8209 Stephen Decatur Highway						21811				_	g. Citizen of What Country? USA		
ad other than "natural", or items 23a or 28a-1 show avant, the Medical Examiner must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  1 Widowed 4 Divorced  12. Was Decedent Ever Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:			? No	1	Was Decede If Yes, specif	,	anic Orig Mexican Specify:	in? (Spe Puerto I	cify Yes or Rican, etc.)	No-			
natur	eted	(Spec	15. Decedent's E cify only highest g	Education rade completed)		16a. Dece (Give	dent's Usual kind of work	l Occupation	on ring most	of workir	ng	16b. K	ind of Busin	ness/Indi	ustry
than the Me	Completed	Elementary/Seco	ondary (0-12)	College (1-4or	(Give kind of work done during most of working life. DO NOT use retired)  Welder					Amusement Park					
markad othar than matic avant, Ina M	To Be C	17. Father's Name Stanley	(First, Middle, Las	_							(First, Midd Sidors		Sumame)		
27 is r trau		19a. Informant's N Kimberly					ng Address ( <b>Meah</b>								Code)
or othe		20a. Method of Dis	1 -	☐Removal from State	, ce	emetery, cre	osition (Name matory or oth	her place)			ate		ocation - Ci		
rtant:		° 4 ☐ Donation	5 Other (Spec	city)	Cap		nlopen					_			
Important: tf Ita any injury or ot once.		21. Signature of Fu	III I a a	4 Rall	0-1		2. Name and 08 Wil				rbage Berlin	Fune . MD	eral F 2181	lome 1	
		23a. Part1. En en t shock, or nea	the disease, or cor art failure. List on	molications that days	the est th										Approximate
sician edical		Immediate Cause disease or condition resulting in death)	(Final	a. Atheros	clero	tic ca						arrest,			Interval Between Onset and Death
edical miner	ai Examiner	disease or condition	onditions, mediate injury s		sclero s a consequ s a consequ	etic ca						allest,			Interval Between
ed in a street and str	cai	disease or condition resulting in death)  Sequentially list confirmed any, leading to income that intrinsed events that initiated events.	onditions, mediate injury s Last	a. Atheros Due to (or a b. Due to (or a c.	sclero s a consequ s a consequ s a consequ e of pregnar 2 □ Fetal	vence of):  vence of):  vence of):  vence of):		rascul					23d. Date o Month	of deliver	Interval Between Onset and Death
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e has been signed by the attending physician and use 2 should be detached for use as the burial-transit	Completed by Physician/Medical	disease or condition resulting in death)  Sequentially list confidence in the confidence or that initiated eventures little in the cast 12 model.  IF FEMALE: 23b. Was deceden in the past 12 model in the past 12 model in the past 12 model in the past 12 model.  Part II. Other signi	onditions, mediate or yet	a. Atheros Due to (or a b. Due to (or a c. Due to (or a d.  23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	s a conseque s a conseque s a conseque of pregnar 2 Fetal at time of de	nence of):  nence of):  nence of):  necy death 3[ auth 5[	ardiov	egnancy ecity)	lar (	lisea	23e. Di 1[ 24a. Wi au pe 1) Yes	d tobacco u  Yes 2  as an topsy formed?  2 \( \) No	Month use contribu  No 3	of deliver	y  Y  Day  Year  cause of death?  bly  4 Munknov
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ctor: After this certificate has been signed by the attending physician and in property the funeral director, page 2 should be detached for use as the burial-transit in property the funeral director, page 2 should be detached for use as the burial-transit in property that the funeral director, page 2 should be detached for use as the burial-transit.	To Be Completed by Physician/Medical	disease or condition resulting in death)  Sequentially list confiancy, leading to in Cause (Disease or that initiated eventuresulting in death)  IF FEMALE: 23b. Was decedent in the past 12 1	And the pregnant conditions injury share to medical end to medical	a. Atheros Due to (or a b. Due to (or a c. Due to (or a d. 23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown contributing to death  Hospital: 28a. Date of Inj (Month, D) on be 28e. Place of Ir building, e	sclero s a consequ s a consequ s a consequ e of pregnar 2 Fetal at time of de but not resu ury ay Year) hiury - At hor to f my know of examinati	tic Catence of):  Hence of of):  Hence of)	DOA  if DOA  if Actory,  th occurred at investigation, in	egnancy scrity)  Luse given  Other:  A Other:  Work?  1   Yes	in Part I.  6. Place 4 Nur t s 2 N	of Death sing Hon 2	23e. Did 1[ 24a. Will 24a.	d tobacco u  Yes 2  as an topsy rformed? 5 2 No y one)  sidence e how injut  (Street ar rown, State ne cause(s) e, date and	Month use contribution of the contribution of	of delivern I Live to the ute to the ute to the ute to the uter autoport to compath?  (Specify)  or Rural  or Rural  Month, D	y Year  Poly 4 Munknow  Sy findings available pletion of cause of Cause of Munknow  Route Number,  Ited.  I

Hudson M 05-3372 AKG

For State	State of Maryland	/ Department of Health and	Mental Hyg	iene	
1 - State Registrar		Certificate of Death		eg. No. 2	5 19700
1. Decedent's Name (First, Middle, La	s: irice Gensler		2. Date of Deat Month	Day Yea	3. Time of Death
cal		4b. City, Town, or Location of Dea	May 15,	2005 4c. County of D	1:59 P M
Anne Arundel Medi	· ·	Annapolis	ith		
5. Social Security Number 6. 3	Sex 7. Age (In yrs. las	t birthday) If Under 1 Year If Under 24 Hr	s. 8. Date of Birth	Anne Aru	INGEL Birthplace (State or Foreign Country)
218-63-4509	1 M 2 □ F 3	Yrs. Months Days Hours Mir	May 13,		Country) aryland
Usual Residence of Decedent  10a. State 10b. County	10a City 3	Town or Location			
_					10d. Inside City Limits 1 ☐ Yes 2\( \) Yes
Maryland Anne Aru	indei	Annapolis  10f. Zip Code	14	On Citizen of 18th at	
3 S. Winchester B	Road	21401		Og. Citizen of What J <b>nited</b> Sta	
11. Marital Status	12. Was Decedent Ever in U.S.				merican Indian,
XX Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	rto Rican, etc.)	Black, W	
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify:	White
15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of wo	orkina	16b. Kind of Busine	ss/Industry
Specify only highest grade [Specify only highest grade]  Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)			
17. Father's Name (First, Middle, Last	1	Not Applicable	ıme (First, Middle, M	ot Applio	cable
m			a Marie J	,	11
19a. Informant's Name/Relationship (	_	19b. Mailing Address (Street and Number or F			
Laurence & Vanessa					
20a. Method of Disposition		e of Disposition (Name of		20c. Location - City	
1X Burial 2 □ Cremation 3 □	Removal from State	etery, crematory or other place)			
`4 □ Donation 5 □ Other (Special		crest Memorial Garden	.8 D/ 19/ UD	Aimapoi	.IB, MD
21. Signature of Funeral Service Lices					
Minhala	* HITT	22. Name and Address of Facility Jo	hn M. Tay	lor Funer	al Home, In
Michele	J. Tutta	147 Duke of Glouce	hn M. Tay ster St.,	lor Funer Annapolis	ral Home, Inc., MD 21401
23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. one cause on each line.	147 Duke of Glouce Do not enter the mode of dying, such as cardia	hn M. Tay ster St.,	lor Funer Annapolis	ral Home, Inc 3, MD 21401 Approximate Interval Between
23a. Part1. Enter the disease, or com	plications that caused the death. one cause on each line.	Do not enter the mode of dying, such as cardia	hn M. Tay ster St.,	lor Funer Annapolis	al Home, Inc., MD 21401
23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the death. one cause on each line.	Do not enter the mode of dying, such as cardia	hn M. Tay ster St.,	lor Funer Annapolis	ral Home, Inc , MD 21401 Approximate Interval Between
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To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number OCME

29d. Date signed (Month, Day, Year) May 16, 2005

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street

Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 1 8 2005

Registrar's Signature

State Registrar

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Marylan	•	ificate of			Reg. No. 2	5 10710
			1. Decedent's Name (First, Middle, Last)					2. Dete of Dee	eth	3. Time of Death
	Physicia		NOAH	DALE H	0000=57	ru		Month 05	24 200	- W
1	/Medic Examin		4a Fecility Name (If not institution, give s		11-04-21	1	4b. City, Town, or			
1	LAdillin	<b>΄</b> Ι	C. W. N. H.				OAKLAN	D	GARK	ETT
	Funeral			7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8 Date of Birt	h 9	Birthplace (State or Foreign Country)
	Director		2/8-24-8570 1X	M 2□ F	6 Yrs.	Months Days	Hours Min.	(Month, Day Aug. 1	3, 1928 1	Maryland
	pue *		10a. State 10b. County	10c. City	, Town or Loca	ation				10d. Inside City Limits
	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heatth end Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ţ	MD GARRETT CARLAND							1 2 Yes 2 □ No
	or 28	Completed by Funeral Director	10e. Street end Number			10f. Zip Code			10g. Citizen of What	
	ath v	E .	201 E. Mason Stre				21550		4.3	
	er de	E I		<ol><li>Was Decedent Ever in U, Armed Forces?</li></ol>	S. 13. W	as Decedent of F Yes, specify Cub	lispanic Origin? (S en, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	Black, W	merican Indian, /hite, etc.
20	irs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 <b>Z</b> Yes 2 □ No If Yes, Give Year or Dates: <b>Kore</b> €	1 I	□Yes 2 No	Specify:		Specify:	VHITE
21215-0020	2 hou	ted	15. Decedent's Educ	ation	16a Decede	ent's Usual Occup	pation	rking	16b. Kind of Busine	ess/Industry
218	e. "n.	pie	(Specify only highest grede	Completed) College (1-4or 5+)	life. DO	O NOT use retire	during most of word d)	King		
2	d with giene.	Š	7th			Laborer			Cons	truction
P	be filed itel Hygi d other event,	Be	17. Fether's Neme (First, Middle, Lest)				18. Mother's Nar	ne (First, Middle,	Maiden Surname)	
Maryland	should be and Mentel amarked or umatic eve	2	Henry Harr	ison I	lardest	•	Anna			Upho1e
lar	2 sho end is me		19a. Informant's Name/Reletionship (Ty)						er, City or Town, Stat	
	and ealth n 27		Beverly E. Grease				Crosscut		akland, M	
Baltimore,	permit. Peges 1 and 2 Depertment of Health e Important: If Item 27 is any injury or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re		lace of Disposi emetery, crema	atory or other pla	се)	Date	20c. Location - City	or rown, State
<u>=</u>	Peg ment: ury		4. ☐ Donation 5 ☐ Other (Specify)		an Gift	t Regist	ry !	5/25/05	Morganto	wn, WV
<u>E</u>	Depert Import any in		21. Signature of Funetal Servicestricense	9		Name and Addre	•		32 S. Seco	
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The	Physician		,							Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition	BLADDER	CANCE	K				7 Vears
			resulting in death)		r es e consequ					1
	si ed	line	_ b							i
	icate be executed physician and s the buriel-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events	Due to (o	r es e conseque	ence of):				
9	be e iician burie	ie i	cause. Enter Underlying Ceuse (Disease or injury							
68760,	ifficate be execu g physician and as the buriel-trai	듛	resulting in deeth) Lest	Due to (or	as a conseque	ence of):				
	certifi nding use as	\$	d					-		
Вох	death cer le attendin ed for use	흥	Part II. Other significant conditions con-	ributing to death but not rec	ulting in the unc	tertving cause gis	en in Part I	23h Did i	obacco use contrib	ute to the cause of death?
P.O.	v requires that the death cert been signed by the attendin should be detached for use	Physician/M	Part II. Other significant conditions con	ributing to death but not lest	alling in the unc	Jenying Cause gn	on in Fait i.			Probably 4 Unknown
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Records,	requires that the reen signed by th hould be detache	Completed by						24a. Was	an autopsy 24	b. Were autopsy findings available prior to
ပ္ပ	lew recias bee	je je						pono		completion of cause of death?
æ	ysician: The lew his certificate has b director, page 2 s	E						101	ras 2jano	1 ☐ Yes 2 ☐ No
of Vital	iffical tor, p	Be C	25. Was case referred to medical				26. Place of Dea	ath (Check only o	nne)	
>	Physician: r this certific rel director,	유	examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□ DOA Oth	ner: 4 Nursing H	lome 5 ☐ Resid	dence 6 Other (5	Specify)
0	g Physical Serence of the serence of		27. Manner of Death	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju	y at	28d. Describe h	now injury occurred	
<u>o</u>	Attanding or death.  actor: After by the fune	윭	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Boy Your)	nijo. y		Yes 2 □ No			
Division	Atta er dei recto	tific	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stree	et, factory, office		28f. Location (5 City or Tox		r Rural Route Number,
0	rs after all Dir	Certification:								
	To the Hospital or Attanding Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	edical	(Check only 2 Medical Examin	icisn: To the best of my known or: On the basis of examinal						
	To the I within 2 To the I complet	Med	one) 29b. Signature end title of certifier	and manner stated.		29c. Licens	se number		29d. Date signed (M	onth, Day, Year)
	5 3 4 S	-	255. Orginature one title of continor			4-	6174			
		-			00-1/7	17 20	015 1		-12	٠ /٥ '
-	34VA		30. Name and address of person who co	mpleted cause of deeth (Item	23e) (Type, P	FA	D. Co.	whlan	5/29 id, MD	21550
*			31. Dete filed (Month, Day, Yeer)	32. Registrer's Signe	ture	· MCV	CS OF C	ana v		
	Sta Bogistr		MAY 2 5 200		K DO	all I				

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 15, 2005 **Physician** 4:40 P Charles Ching-Chiu Hsu /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery 4924 Sentinel Drive 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Months Days Hours Min. Director 160-32-7157 70 19, 1934 Taiwan Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County Show ral', or Items 23a or 28e-f show Exercit er must be retified at 1 Yes 2 No Directo Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4924 Sentinel Drive #402 20816 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ ∑No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or Iten any injury or other traumatic event, If Wedlog Exercited Once. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Asian Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired)
 Off 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Central Intelligence Officer College (1-4or 5+) Elementary/Secondary (0-12) Agency Undercover Intelligence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Yui-Ju Chen P Ma-Wong Hsu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4924 Sentinel Drive #402 Bethesda, MD 20816 Kyoko Y. Hsu/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 18, 1 ☐ Burial 2 XCremation 3 ☐ Removal from State <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) W. Arundel Crematory 2005 Odenton, Maryland Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Intra ora Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events nding physician and resulting in death) Last Due to (or as a consequence of). Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? death? certificate 1 X Yes 2 No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6X Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA at scene Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending Injury Deceased shot sel 1 Natural 1 Yes 2 No 16:25 PM death. investigation 5-15-05 2 Accident Director: the 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4974 Sept. CDC. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide hone Ketherda MD within 24 hours a To the Funerel L 29a. Continue Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME May 16, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registar's Signature State

DHMH 17 Rev 1/2001

Registrar

2005

			1 - For State Registrar	State of M	laryland	-	artment of H		nd Mental H	ygiene		
1	División		1. Decedent's Name (First, Middle	Last)		*-	<del></del>		2. Date of D	eath (	UUJ	3. Time of Death
	Physici /Medio		George	Edward		Hi	1debrand	<u> </u>	Month	28, <sup>Day</sup>		8:20am <sup>™</sup>
	Examir		4a. Facility Name (If not institution,		)		4b. City, Town, o	or Location of D		4c.	County of Death	
			3437 Buckeysto					ystown			Freder	
	Funeral Director		217-18-8697	6. Sex 7. Ag 1 🖾 M 2 🗆 F	ge (In yrs. la 83	Yrs.	If Under 1 Year Months Days			irth Day, Year) 1921	9. Birth Cour Mary	place (State or Foreign http:/ land
	iand iand		Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Loc	cation				1	10d. Inside City Limits
	Mary feb	ō	Maryland Fred	erick		Bucke	ystown					1 Ves 2 No
	r 28a	irec	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Cour	ntry?
	th with	a D	3437 Buckeysto	wn Pike			217	17		U	S.A.	
	ams ams	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces	?	1f	Vas Decedent of H	lispanic Origin	? (Specify Yes or Note:)	10-	14. Race - Americ	
036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f ehow fa Marileal Exar ilhet r uat be neitlied at	þ	1 Never Married 2 🖫 Marrie 3 Nidowed 4 Divorced		No 1943	3-	☐ Yes 2∑ No		dello ricali, etc./		Black, White,  Specify:  Wh	nite
5-0	72 ho	Completed	15. Decedent' (Specify only highest			16a. Deced	ent's Usual Occup	ation	l working	16b. Kir	nd of Business/In	
7	ithin Ben M	nple	Elementary/Secondary (0-12)	College (1-4or	5+)	life. D	OO NOT use retired	d)				
2	led w lygier her ti		12			Pers	onnel Sp					overnment
lanc	id be fi ental h kad ot c evar	To Be	17. Father's Name (First, Middle, L Coleman	asr)	Hilo	debran	d	18. Mother's Mabe	Name (First, Middl	e, Maiden .	,	elser
ary.	shound M	-	19a. Informant's Name/Relationsh	ip (Type, Print)	- 1	19b. Mailing	g Address (Street	and Number o	or Rural Route Num	ber, City or		
ž	and 2 alth a 127 is		Rowena Pfeifer	Hildebrand/	Wife							stown 2171
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healin and Mental Hygiene. Importanent of Healin and Mental Hygiene. Importanent: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, Ita Mariled Examinate mail to notified an once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		cer	nce of Dispos metery, crem	sition (Name of latory or other place)  Cemeter	ce)	Date	20c. Loc	cation - City or To	
Ħ	nit. P artme ortan injury		<ul><li>4 □ Donation 5 □ Other (Sp.</li><li>21. Signature of Funeral Service L</li></ul>		110		Name and Addre		51, 2005	110	derick,	Maryland
B	Depa Impo any it		A CO O	VB.	J MOO-				ord P.A. Street,	Euner	al Home	
			23a. Parri. Buter the divease, or o	complications that cause	MOO7 d the death.	Do not ente	Ub Last Ir the mode of dyin	Church 1g, such as car	Street,	rede	rick, M	21701 Approximate Interval Between
	Physician		shock, or heart failure. List o Immediate Cause (Final	nry one cause on each t	Orech	0. n	Ween ca. of	100 T	n lared			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as	a conseque	ence of):	Jecover	iac s	nfaceto.	~		
	Examiner		Sequentially list conditions,	h			*					
	D #	Iner	t any, leading to immodule cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a conseque	moa of):						
	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.								
8760,	be ex ician burial	a E	,	Due to (or as	a conseque	ence or):						
687	phys phys s the	dlcal		d								
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						2	3d. Date of delive	
m.	death d for	iclai	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pregnancy Other (specify)	'		-		Day Year
o.	t the de by the tached	hys	9 Unknown	9□ Unknown								
S, D	signed h	ру Р	Part II. Other significant condition		out not result	ting in the und	derlying cause give	en in Part I.	23e. Did	tobacco us	se contribute to th	e cause of death?
or C	w requir been si should		Hypert	nentia					_ 1 🗆	Yes 2. ₽	No 3 ☐ Prob	ably 4 Dunknown
Record	e law r has be je 2 sh	Completed	Der	nentia					24a. Was		24b. Were autop	osy findings available
<u> </u>	The cate has page	Con							perf 1 ☐ Yes	ormed? 2 No	death?	2 No
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	l Hamaina					Death Check only	one)		
o	Physi this c	70	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital:		R/Outpatient		4 LI NUISIN	ng Home 5 Res			)
Division of	ding F	tlon	1 Natural 5 Pending		ly Year)	28b. Time of Injury	28c. Injun Work	/ at <br Yes 2 □ No	28d. Describe	how intury	occurred	
18	Attand death ctor: / y the f	fical	3 ☐ Suicide 6 ☐ Could no	t be	iurv - At hom	ia, farm strei		162 Z   NO	28f Location	Street and	Number or Rural	I Route Number
<u>S</u>	al or A after I Dira d in b	Certification;	4 Homicide determin	28e. Ptace of Initial building, et	ic. (Specify)	,,	ot, lactory, office		City or To	wn, State)	reamber of Harar	r nodia wainber,
	To the Hospital or Attanding Physician: within 24 hours after death To the Funeral Director. After this certifica completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best xaminer: On the basis o and manner st	if examinatio	edge, death on and/or inve	occurred at the timestigation, in my op	ne, date and pl	lace, and due to the occurred at the time,	cause(s) a	and manner as sta place, and due to	ated. the cause(s)
	To the Hos within 24 ho To the Fun completely	Me	29b. Signature and title of certifier	and mariner ste			29c. License	number		29d. Date	signed (Month, L	Day, Year)
			7	yes N	11) .		Т	054636		Моч	31, 200	5
	1	İ	30. Name and address of person w	no completed cause of d	leath (Item 2	23a) (Type, P		-5 1000		riay	JI, 200.	J
	10		Syed W. Haque				Avenue,	Frede	rick, Mar	yland	1 21701-	4509
	Stat Registra		31. Date filed (Month, Day, Year)  JUN 0 3	2005 32. egistr.	rar's Signatur	do	de					

			0) 1	artment of Health and Menta	2005 10710
			Decedent's Name (First, Middle, Last)		Reg. No. 3. Time of Death
	Physic		MABEL PRIBBLE HUDSON	Mor	nth Day Year
	/Medi Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Y 22, 2005 7:35 P <sup>M</sup> 4c. County of Death
			3875 MARVIN DRIVE	INDIAN HEAD	CHARLES
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs.   8. Date	e of Birth
	Director		225-03-6265 1□M 2XIX 89 Yrs.		onth, Day, Year)  Y 2,1915 VIRGINTA
	and		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L		
	larytan ehow	ក	Was a superior and a		10d. Inside City Limits
	the M	Director	MARYLAND CHARLES INDIAN  10e. Street and Number		1 ☐ Yes 2⁄QNo
	with e or		3875 MARVIN DRIVE	10f. Zip Code	10g. Citizen of What Country?
~	leath w ns 23e	era		Was Deceded of Hispania Origins (Specify Vac	U.S.A. s or No- 14. Race - American Indian,
"	fter dea	Funeral	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e	Black, White, etc.
8	hours af turel', or	by		1 ☐ Yes 2X No Specity:	Specify: WHITE
20	s within 72 hours after death with the Maryland ilone. I then "neturel", or Items 23e or 28e-f ehow Ite Modical Examirer met Le motified at Ite Modical Examirer.	Completed	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b. Kind of Business/Industry
2	within ene. then	nple	(Specify only highest grade completed) (Give life.	kind of work done during most of working DO NOT use retired)	
21	77 2 6 6	Co		MAKER	OWN HOME
n d	od of o	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, M	Middle, Maiden Sumame)
3	should be and Mental marked of umetic eve	٩	FLETCHER PRIBBLE		RTHUR
Maryland 21215-0036	12 sho hand 7 ie ma treum			ng Address (Street and Number or Rural Route in	
	s 1 and 2 should f Health and Mer item 27 ie marke other treumetic		KATHY H. MOORE-DAUGHTER 3875  20a. Method of Disposition 20b. Place of Dispo	MARVIN DRIVE, IN Date	DIAN HEAD, MD 20640
altimore,	Pages nent of int: If it		1∑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, createry, createry, createry	matory or other place)	20c. Location - City or Town, State
틆	iit. P. artme ortent injury		*4 □ Donation 5 □ Other (Specify) TRINITY MEN  21. Signature of Funeral Service Licensee MOO479	ORIAL GDNS. 5-26-0	05 WALDORF MARYLAND
Ba	permit. Pages Department of the Importent: If ite eny injury or of			2. Name and Address of Facility . AYMOND FUNERAL SER	RVICE, P.A.
	4 4		23a Part 1 Enter the disease or complications that haused the death. Do not only	A PLATA, MARYLAND	20646
6			Immediate Cause (Final	A STATE OF THE STA	Interval Between Onset add Death
	Pnysician /Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	P	1/7/2005
	Examiner		De de la consequence on)	Ś	weeks
	E E	Je.	if any, leading to immediate  Due to (or as a consequence of):		11 616
	cuted nd ransil	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  C.		
0,	e exe ian ai urial-t		resulting in death) Last Due to (or as a consequence of):		
8760,	cate be executed physician and the burial-transit	dicai	d		
9	leath certific attending p	Mec	IF FEMALE:		
Вох	death certifi e attending I od for use as	jan/		Ectopic pregnancy	23d. Date of delivery  Month Day Year
o.	0 0 0	Physician/Me	1 ☐ Yes 2 ♣No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown 5 ☐	Other (specify)	John Day 76ai
_	es that the de igned by the a be detached	H-	Part II. Other significant conditions contributing to death but not resulting in the un	tderlving cause given in Part I. 23e.	Did tobacco use contribute to the cause of death?
Records,	The law requires that the tee has been signed by the bage 2 should be detache	d by			1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣☐Unknown
00	w requir been s should	lete		242	
	he tav e has age 2	Completed			Was an autopsy findings available prior to completion of cause of death?  Yes 2√2 No 1 ∨ Yes 2 ∨ No
Vital		O	25. Was case referred to medical	1 \( \) \( \	
	S S	O B	examiner?  1 Yes No Hospital: 1 Inpatient 2 ER/Outpatien	Other	Residence 6 Other (Specify)
0	ding Ph n. After th funeral	T: L	27. Manner of Death 28a. Date of Injury 28b. Time of		cribe how injury occurred
0	Attending r death. ector: After by the fune	atlc	2 Accident investigation	M 1 Yes 2 No	
Division of	after death after death Director: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, strubuilding, etc. (Specify)		tion (Street and Number or Rural Route Number, or Town, State)
	urs al				
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier (Check ony one)  Certifying Physician: To the best of my knowledge, death (Check only one)  Medical Examiner: On the basis of examination and/or invand manner stated.	occurred at the time, date and place, and due to estigation, in my opinion, death occurred at the	o the cause(s) and manner as stated. time, date and place, and due to the cause(s)
	To the To the Comple	Med	29b. Signature and title of certifier 1	29c. License number	29d. Date signed (Month, Day, Year)
	rs⊢ó		M. M. Alchelane m	46046	5/24/2005
4	. 1	-	30. Name and address of person who completed cause of death (Item 23a) (Type,		1-1-1
	10		Dr. Amir A. Mirza Alikhani, 118 LaGra	'	20646
100 m	Sta		31. Date filed (Month, Hay Year) 32. Hagistrar's Signature	o ave uarrata, III.	<del>20040</del>
100	Registra	ar	JUN 0 3 2000 Alakar IF	and a	

		1	For State Registrar	State of M	laryland /		artment of H		nd Meni		ene . No. 0 0 1	jerone Length	187	111.
È			Decedent's Name (First, Middle,	Last)						ate of Death	7447	ear	3. Time o	f Death
	Physicia /Medic		MARGA	ARET H_	HOLMI	ΞS			Ma	_			2:50	A M
	Examin		4a. Facility Name (If not institution,	give street and number	-)		4b. City, Town, or	Location of	Death		4c. County of	Death		
			Frederick Mer			1 ab 1 1	Frederi If Under 1 Year	. C k	4 Hrs. I o. 5	at a d Diadh	Frede			
	Funeral Director		226-26-5322	6. Sex 7. A 1 □ M 2 □ F	ge (In yrs. last b	Yrs.	Months Days	Hours	Min. (/	eate of Birth Wonth, Day, Y rch 7,	<sup>(ear)</sup> 1924	Wes	ace (State ry) st Vir	ginia
	and and 1	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation					10	d. Inside C	ity Limits
	Mary	to	Maryland Fr	ederick			Fr	ederio	ck				1 XYes	2 □ No
	n 28a	rec	10e. Street and Number				10f. Zip Code			100	g. Citizen of Wha	at Count	ry?	
	th wit	al D	222 Broadwa	ay				2170				.S.A		
9	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or Items 23a or 28a-f show ther than Madical Exertimetrount te notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2☐ Marrie	12. Was Deceder Armed Forces 1  Yes 2 If Yes, Give	?		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes	ispanic Origi n, Mexican, Specify:	in? (Specify Puerto Ricar	Yes or No- n, etc.)	14. Race - Black, SpecifyW	White, e	etc.	
-003	tural',	ed by	3 XWidowed 4 ☐ Divorced  15. Decedent*	Year or Dates	:	a Dece	tent's Usual Occupa	ation		16	3b. Kind of Busin			
21215-0036	rithin 72 ne. nan "na e Madic	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-40		(Give life.	kind of work done of DO NOT use retired emaker	during most ( )	of working		Own H	omo		
	Hygier Hygier Ther ti		17. Father's Name (First, Middle, L	ast)		пош	ellaker	18. Mother	's Name (Fir	st, Middle, Ma	aiden Surname)	JIIIE		
land	lid be f lental h ked of	To Be	Denny Henderson						dia Sa					
Maryland	and 2 should be filed within eath and Mental Hygiene. n 27 is marked other than "ner traumatic event, the Mes	-	19a. Informant's Name/Relationsh Glenn Richard H	<sub>ip (Type, Print)</sub> Io1mes/Son	19	P. Maili	ng Address <i>(Street a</i>	and Number 32, Fi	ro <i>r Rural Roi</i> rederi	ck, MD	City or Town, Sta 21702	ite, Zip	Code)	
Baltimore,	_ = = =		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☑ Donation 5 ☐ Other (Sp.		come	tery, crei	sition (Name of matory or other plac etery	<sup>e)</sup> May 2	Date 27, 20		oc. Location - Ci	-		and
Baltir	permit. Pages 1 Department of H Important: If ite any injury or ot		21 St natyle of Funeral Service I	icen A	Q10002		2. Name and Addres	Racto	rd Fun	eral H	ome			
8,760,	certificate be executed  Washing physician and ding physician and asset the burial-transit	cal Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of the shock is a shock or heart failure. List of the shock is a shock or heart failure. List of the shock is a shock or shock or shock is any leading to immediate cause. Enter Underlying Cause (Disease or in injury that initiated events resulting in death) Last	a. Due to (or a b. Due to (or a c.	ed the death. Do ne. as a consequence as a consequence as a consequence	e of):	er the mode of dyin	g, such as c	ardiac or res	pirāt <b>d</b> ry arres	st,	/. 	Approxima Interval Be Onset and	tween
.O. Box 6	death certifi e attending i ed for use as	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		2 Fetal dea at time of death		□Ectopic pregnancy □ Other <i>(specify)</i>				23d. Date of Month		ry Day	Year
ds, P	requires that the een signed by th nould be detache	b	Part II. Other significant condition	ns contributing to death	but not resulting	j in the t	nderlying cause give	en in Part I.	_	23e. Did toba 1 ☐ Yes	acco use contribi	ute to the		death?  Unknown
Records,	e tav has je 2	Completed								24a. Was an autopsy perform 1 Yes 2	ed2 dea	ere autop or to com ath? ] Yes	osy findings npletion of No	available cause of
of Vital	yaician: Th is certificate director, paç	Be (	25. Was case referred to medical examiner?				04	The second second		eck only one				
Ť	Phyaician: this certific ral director,	2	1 Yes 2 16		tient 2 ER/	Outpatie					nce 6 Other		')	
n C	the free	lon	27. Manner of Peath  1 Natural 5 □ Pendin investig	g (Month, i	Day Year)	Injury	Wor	k? Yes 2∐N		Describe nov	v injury cocurred			
Division	or Attending ifter death. Director: Afte	Certification;	2 Accident Investig 3 Suicide 6 Could i 4 Homicide determ	at ha	Injury - At home, etc. <i>(Specify)</i>	farm, st	reet, factory, office		28f.	Location (Stre City or Town,	eet and Number State)	or Rurai	l Route Nui	mber,
	Hospital 24 hours a Funeral I tely filled	edical Ce	29a. Certifier Check only one) Certifyin	g Physicien: To the be Exeminer: On the basis and manner	of examination	ige, dea and or in	th occurred at the tire	ne, date and pinion, deat	d place, and th occurred a	due to the car t the time, da	use(s) and mann te and place, and	er as sta d due to	ated. the cause	(s)
	To the within 2 To the comple	Me	29b. Signature and title of Pertifie	Pfant	1		29c. Licens	e number	7/	29	d. Date signed (	Month, L	Day, Year)	
	^		30. Name and address of person	who completes cause of	of death (Item 23)	a) (Type	Print)	-//			1-4/	- 7		
	2		Robert L.	Kaufmann.			est Ninth	Stre	et Fr	ederic	k MD 2	1701		
		ate	31. Date filed (Month, Day, Year)	32. Peg	strar's Signature		7		,		,	_, 01		
	Regist	rar	JUN 0 ;	3 2005   1	we &	1	The state of							

DHMH 17 Rev 1/2001

ORIGINAL

	1		For State Registrar	State of Ma	aryland / Depa	artment of H			iene g. No. 2 0 (	5 18715
	Physicia		1. Decedent's Name (First, Middle, Last)	Fannie	Horst			2. Date of Deat Month May	Day Y	3. Time of Death (9ar (05 4:30 A. M
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Deat		4c. County of	
			Mennonite Fellows	-	d	Hagerst	OWN If Under 24 Hrs.	lo Barrad Bird	1	ngton
	Funeral Director		5. Social Security Number 6. Sex 1□	M 213 F	(In yrs. last birthday) 85 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Jan. 27	1920	9. Birthplace (State or Foreign Country) Maryland
	D		Usual Residence of Decedent		10c. City, Town or Lo					10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show rmust be notified at	ō	MD. Washingto	on	Hagers					1 Yes 2 No
	r 28a-	rect	10e. Street and Number			10f. Zip Code		11	0g. Citizen of Wh	at Country?
	th with	al D	12349 Huyett Lane			21740			U.S.A.	
30	be filed within 72 hours after death with the Marylar at all Hygiene.  Ide Hygiene.  Ide Arbeiteal Examinat must be notified at event, the Madical Examinat must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 ☐ Yes 2 10 N If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	Black,	American Indian, White, etc. White
2-003b	72 hou	ted	15. Decedent's Educ (Specify only highest grade	ation	16a Dece	dent's Usual Occupa	ation furing most of wo	rkina	16b. Kind of Busi	ness/Industry
7	within 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	kind of work done of DO NOT use retired	)		Home	
V	e filed within al Hygiene. I othar then " went, the Wei	Be Co	17. Father's Name (First, Middle, Last)		110	memaker	18. Mother's Nar	ne (First, Middle, M	Maiden Sumame)	
/land	2 should be 1 and Mental 1 is marked o raumatic eve	To B	Martin E. Hors	t			Anna k	. Martin		
Mar	2 sho and ? Is ma		19a. Informant's Name/Relationship (Type Joe P. Horst/Hus)			ng Address (Street &				
o,	1 and 2 Health tem 27 is		20a. Method of Disposition	oand	20b. Place of Dispo	9 Huyett		and the second s		ity or Town, State
altimor	Pages nent of int: If it iry or o		1 XBurial 2 ☐ Cremation 3 ☐ Ro 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Mt. Oliv	matory or other place e Mennoni emeterv	te 5/28	3/05	Maugansv	ville, Md.
Balt	permit. Pages 1 and 2 should I Department of Health and Men Important: If item 27 is marke any injury or other traumatic.		21. Signature of Funeral Service License	mem	2	2. Name and Addres immerman	And Son	Funeral I	Home Inc	. 17225
~	Centificate be executed  Medical  Medic	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):  OSCLERO a consequence of):	FD(A)	MFA	RCTION	TERY	Approximate Interval Between Onset and Death O MINUTES
8/60,	ate be exe hysician a the burial-	ai Ex	resulting in death, cast	Due to (or as	a consequence of):					
ŏ	at Şe	edicai								
O. Box	death e atter	Physician/M	IF FEMALE: 23b. Was decedent pregnapy in the past 12 months? 1 □ Yes 2 □ ₩6 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Monti	•
rds, P	law requires that the de as been signed by the a 12 should be detached f	þ	Part II. Other significant conditions con	tributing to death b	ut not resulting in the u	underlying cause give	en in Part I.	23e. Did tob	_ /	ute to the cause of death?
I Records,	The ate h page	Completed						24a. Was an autops perform	ned?   de	ere autopsy findings available or to completion of cause of ath? □ Yes 2 □ No
Vital R	ıysician: Th is certificate director, paç	Be	25. Was case referred to medical examiner?	ospital:		Othe		ath (Check only on		
	Phys r this eral-dir	. To	1 ☐ Yes 2 1 No  27. Manner of Death	1 ☐ Inpatie 28a. Date of Inju (Month, Da		nt 3∐ DOA	4 Divursing r	lome 5 Reside		
o O	Attending Physician: ir death. actor: After this certific by the funeral-director.	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year) Injury		c? Yes 2 □ No			
Division of	al or Atte s after de l Diracto d in by th	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (St City or Town	reet and Number n, State)	or Rural Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funerel Diractor: completely filled in by the	edical (	29a. Certifier 1 Certifying Physical Certifier (Check only one)	sician: To the best ner: On the basis of and manner sta	of my knowledge, dea f examination and/or in ated.	th occurred at the time the ti	ne, date and place pinion, death occ	e, and due to the caurred at the time, d	ause(s) and mani ate and place, an	ner as stated. d due to the cause(s)
	To th withir To th comp	Me	29b. Signaure and title of certified	D Person	al Physic	29c. License		1359	9d. Date signed of MAY	(Month, Day, Year) 24 2005
	4		30. Name and address of person who co	mpleted cause of c	leath (Item 23a) (Type	Y. Hay	erstou	x, Md	2170	12
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  JUN 0 3 20		ar's Signature	new		(		

Registrer Certificate of Death Reg. No.
1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
Physician MARY EMILY JONES  Month Day Year 0205
/Medical Examiner  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
Peninsular Regional Medical Center Solisbury Willowice
Catific with Number of Say 7 App (In visc last high-day) If Linder 1 Year If Under 24 Hrs 9 Date of Right
Funeral Director 219-14-4020 1 M 2 M F 80 Yrs. 80 Yrs. Months Days Hours Min. (Month, Day, Year) 80 Aryland
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limi
10a. State   10b. County   10c. City, Town or Location   10d. Inside City Limit   10d. Inside
MD Caroline Federalsburg 1 Taxyes 2 In the control of the control
10a. State   10b. County   10c. City, Town or Location   10d. Inside City Limit   10d. State   10d. Inside City Limit   10d. State   10d. Inside City Limit   10d. Street and Number   10d. Street and Number   10d. Street and Number   10d. Street and Number   10d. City, Town or Location   10d. Inside City Limit   10d. I
The state of the specific of t
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc. Black, White, etc. Black, White, etc.
1 □ Never Married 2 □ Married 1 □ Yes 3 □ No Specify: Specify: Black  Specify: Black
15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
(Give kind of work done during most of working life. DO NOT use retired)    College (1-4or 5+)
15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  10  E
17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
Benjamin Haynes Anna Gertrude Truxon
19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Anna J. Dotson/Daughter 1513 Rawlings Well Rd. Baltimore, MD 2122
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
1 XBurial 2 Cremation 3 Removal from State Federal Hill Cem. 5/9/2005 Federalsburg, MD
21. Signature of Funeral Service Licensee 22. Name and Address of Facility 216 N. Main St. Federalsbu
21. Signature of Funeral Service Licensee 22. Name and Address of Facility 216 N. Main St. Federals bu Framptom Funeral Home, PA. MD, 2163
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
nysician Immediate Cause (Final disease or condition April 19 Character Bowel
Medical resulting in death)  a
xaminer Renel Tailure
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  Beginning to immediate cause. Enter Underlying Cause (Disease or injury)  A S C V D
fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last  Due to (or as a consequence of):  A C U  Due to (or as a consequence of):  Due to (or as a consequence of):
that initiated events resulting in death) Last Due to (or as a consequence of):
physicial dical dical
Stand Burgle   Stan
IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy   Month Day Year   Year   Yes 2   No 9   Unknown   Year   Year   Yes 2   No 9   Unknown   Year   Year   Yes 2   Yes 2   Yes 2   Yes 2   Yes 3   Yes 4
4 Pregnant at time of death 5 Other (specify)
1 Votes of the state of the st
1   Yes 2   No 9   Unknown   9   Unknown   9   Unknown   Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknown   24b. Were autopsy findings availated in the underlying cause given in Part I.
1 Yes 2 No 3 Probably 4 Onknow
24a. Was an autopsy findings availate performed? performed? 1 Yes 2 No 1 Yes
performed?   death?
1 Yes 2 No  1 Yes 2 No  25. Was case referred to medical examiner?  26. Place of Death (Check only one)  Hospital:
25. Was case referred to medical examiner?  1
25. Was case referred to medical examiner?  1 Yes 2 No North, Day Year)  25. Was case referred to medical examiner?  1 Yes 2 No North, Day Year)  26. Place of Death (Check only one)  26. Place of Death (Check only one)  Cher: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Manner of Death  1 Natural 5 Pending investigation  28a. Date of Injury  (Month, Day Year)  28b. Time of Injury  M 1 Yes 2 No
27. Manner of Death 1
2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28g. Certifier 29a. Certifier 29a. Certifier 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
Ce ta Digital State of
29a. Certifier (Check only one) and manner stated.  29b. Signature and title of certifier (29b. Signature and title of certifier (20b.
and manner stated.
On License sumber
29b. Signature and title of certifier  29d. Date signed (Month, Day, Year)
29b. Signature and title of certifier  29c. License number  1400 17 410  29d. Date signed (Month, Day, Year)
29b. Signature and title of certifier  29c. License number  400 5 7 40  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
20 140057910 511/05

DHMH 17 Rev 1/2001

			For State Registrar	State of M	<b>1</b> arylan	-	artment of I tificate of				jiene ()	05	18717
	Physici	an	Decedent's Name (First, Middle Margaret Emma							2. Date of Dear Month 21,		Year	3. Time of Death 7:00A M
	/Medic Examin		4a. Facility Name (If not institution		r)		4b. City, Town,			y == ,	4c. County		
			Kline Hospice			for a fine fine for a 1	Mt.		24 Hrs	Date of Diet	Frede		
	Funeral Director		5. Social Security Number 217–03–1258	6. Sex 7. A	87	last birthday) Yrs.	Months Days			B. Date of Birth Month, Day OCt. 31	,1917	Mar	place (State or Foreign ntry) <b>y Land</b>
	and and I		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	10d. Inside City Limits
	Maryl a-f sho ified a	tor	Maryland Frede	erick	Th	urmont							Yes 2 No
	with the	Funeral Director	10e. Street and Number 115 Easy Street	Hode 22			10f. Zip Code <b>217</b>	QQ		1	Og. Citizen of	What Cour	ntry?
	ns 23g	era	11. Marital Status	12. Was Deceden	nt Ever in U.	S. 13.1	Was Decedent of f Yes, specify Cut		igin? (Spec	ify Yes or No-			can Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar must be notified at ance.	þ	1 Never Married 2 Mar 3 Widowed 4 Divorced	If Yes, Give	No No		f Yes, specify Cut 1 ☐ Yes 2 ☐ XNo			ican, etc.)	Specif	ck, White,	etc. White
5	"netur	leted		nt's Education st grade completed)		(Give	dent's Usual Occu kind of work done DO NOT use retire	during mos	t of working	g	16b. Kind of B	usiness/In	dustry
21215-0036	d withir jiene. r than the Ms	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)		brarian	<del>,</del>			Town I	Libra	ry
Maryland	d be file antal Hyg red othe	To Be C	17. Father's Name (First, Middle, Harry	Last)		Kr	one		er's Name ( ary	(First, Middle, I	Maiden Sumar <b>E</b> .	пе)	Stein
ary	should and Me e mark tumation	ĭ	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Address (Stree	t and Numb	er or Rural	Route Number	r, City or Town,	State, Zip	Code)
S ô	t and 2 dealth sm 27 I		Joan Knott/Daug	ghter	20h P		Highfie	1d Roa	ad, Ca		MD 217		own State
altimore,	ages ent of h nt: If ite y or of		1 Burial 200 remation 4 Donation 5 Other (5		e 0	emetery, crer	cremato		5/24/0		Frederi		
Baltii	permit. F Departm Importar any inju		21. Signature of Funeral Service				Name and Addr						
r			23a. Part1. Enter the disease, of shock, or heart failure. List	complications that caus	ed the deatl	h. Do not ent	er the mode of dy	ing, such as	cardiac or	respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	-a esc	pho	rgea	& ca	nce	1				Onset and Death
	/Medical Examiner			Due to (or a	is <sup>v</sup> a conseq	uerige of):							
	P #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a conseq	uence of):							
	execute and al-trans	Examiner	that initiated events resulting in death) Last	c	ıs a conseq	uence of):						-	
8760,	icate be executed physician and s the burial-transit			d									
9	eath certifica attending ph for use as th	/Med	IF FEMALE:	23c. If yes, outcom	ne of pregna	incv					22d Da	te of delive	00/
.O. Box	0 0	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 □Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta at time of d	Ideath 3	Ectopic pregnand Other (specify)	су				onth	Day Year
<u>α</u>	res that the de signed by the a be detached t	by Ph	Part II. Other significant conditi	ons contributing to death	but not res	ulting in the u	nderlying cause g	iven in Part	l.	23e. Did to	bacco use con	tribute to t	he cause of death?
ords	w require been sig should b									1 🗆 Y	es 2□No		oabły 4 ∐Unknown
Division of Vital Records,	The lar	Completed	er de la companya de							24a. Was a autops perform	med?	prior to co death?	opsy findings available impletion of cause of
Vita	Physician: The ribis certificate ral director, pag	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Hospital:	tiont 2	ER/Outpatier	nt 3□ DOA	ther		(Check only on e 5 ☐ Reside	/	K lin	HOSPICE
n of	ding Phys h. After this funeral di	<b>—</b>	27. Manner of Death 1 ☑Natural 5 ☐ Pendi	28a. Date of in		28b. Time o Injury				Bd. Describe ho			HO.000
isio	Attending r death.	ertification:	2 ☐ Accident invest	igation		ome farm str		Yes 2		Bf. Location (S	treet and Numi	ber or Rura	al Route Number,
Δ	el or Attences after death	Certif	4 ☐ Homicide determ	building,	etc. (Specif	y)	eet, factory, office	1		City or Town	n, State)		,
	To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	edical		ng Physician: To the bea I Examiner: On the basis and manner	of examina								
)	To the within 2 To the I complet	M	29b. Signature and title of certific		10		29c. Licen	se number +818	4	2	29d. Date signe 5 23		Day, Year)
<	В		30. Name and address of person Elhamy ESK	who completed cause of	f death (Iten	n 23a) (Type,		1th	stma	t F			D 21701
	Sta	ate	31. Date filed (Month, Day, Year	) 32. Regi	rar's Signa			/ "	1114	( J (			2011
	Regist	rar	MAY	2 3 2005	Helm	J.	Annie Control						

		1	For Stete Registrar	State of I	Maryland / Depa <i>Ce</i>	artment of H			ene200	5 18718
			Decedent's Name (First, Midd	lle, Last)		-		2. Date of Death	Day Yea	3. Time of Death
	Physicia /Medic	_	Catherine Elea	nor Keller				Month	18 20	
	Examin	_	4a. Facility Name (If not institution			7.	Location of Death	)	4c. County of D	
			Western Maryla			Hager			Washi	
	Funeral		5. Social Security Number	6. Sex 7. 1 ☐ M 2 🕱 F	Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	<sup>(ear)</sup> 1928	Birthplace (State or Foreign Country) Maryland
	Director	-	186-24-9296 Usual Residence of Decedent		76			July 31,	1920	Haryrand
	/land		10a. State 10b. County	у	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Man 9-1 sh	to	Maryland Fred	lerick	Freder	ick				1 X Yes 2 □ No
	th the	Funeral Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What	-
	23e	rai	615 Himes Aven			2170			U.S	
	er des Items	nue	11. Marital Status	12. Was Decede Armed Force	s?	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		merican Indian, /hite, etc.
36	rs afte	by F	1 ☐ Never Married 2 ☐ Mai 3 ☐ Widowed 4 ☐ Divorce	If Yes, Give	s:	1 ☐ Yes 2 🛣 No	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f show he Modical Examiner must be notified at	ed 1	15. Decede	nt's Education	16a. Dece	dent's Usual Occupa	ation	. 16	Bb. Kind of Busine	ss/Industry
75	hin 72 en en	pie	(Specify only higher Elementary/Secondary (0-12)	est grade completed)  College (1-4)	or 5+)	kind of work done of DO NOT use retired	during most or wor d)	xing		
2	od with	Completed	12			roduce Cl				/Grocery
ם	be file tal Hy d oth	Be (	17. Father's Name (First, Middle					ne (First, Middle, Ma		
Maryland	Ment Ment Marke	ို	George Benjami				Thelm			. 77 0-1-1
Nar	12 sh h and 7 is m traum		19a. Informant's Name/Relation					rai Route Number, (		
e,	1 and Healti em 2	-	Henry L. Kelle  20a. Method of Disposition	er/Husband	20b. Place of Disp	osition (Name of			ck, mary 0c. Location - City	1and, 21703 or Town, State
Ď	ages nt of l t: If it	1	1 Burial 2 Cremation		ite	matory or other plac		1 /2005	Fredoric	k, Maryland
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be rutified at once.	1	' 4 □ Donation 5 □ Other (		Resthaven M	2. Name and Address	Company of the compan	1/2005		ast Church Street
æ	Dep Imp		P. Regan	_ MEM	Elian K	eeney and B	asford P.A	. Funeral Ho		rick, MD, 21701
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that cau	sed the death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between
E	Physician		Immediate Cause (Final disease or condition	Oppu	cresting.	Least	Faile	UL		Onset and Death
ı	/Medical		resulting in death)	a. Due to (or	s a consequence of):		0	- 00		
ı	Examiner		Sequentially list conditions	b. Car	man a	sterry	he	ase		years
-	D i	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequence of):	V				0
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to /or	as a consequence of):					
8760,	death certificate be executed e attending physician and of for use as the burial-transit			540 (5)	as a somosquemos siy.					
387	physicate sthe	Physician/Medical		d						
9 X	that the death certific ed by the attending p detached for use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco		-			23d. Date of	delivery
Box	death a atter	ciar	in the past 12 months?	4□Pregnan	t at time of death 5	⊒Ectopic pregnancy ⊒ Other (s <i>pecify)</i>	<u>'</u>		Month	Day Year
P.0.	t the c by the achec	hys	9 Unknown	9∐ Unknow	n					
	law requires that the as been signed by th 2 should be detache	by P	Parvil. Other significant condit	tions contributing to deat	h but not resulting in the	anderlying cause give	en in Part I.		-/	e to the cause of death?
ğ	en sig	pa	Respiratory	Jarline,	Ventillet	n befle	ndent	1 ☐ Yes	2 XNO 3	Probably 4 Unknown
S	e faw re has be ge 2 sh	ompleted	Chronic	Kerial	& rease	V		24a. Was an autopsy	prior	autopsy findings available to completion of cause of
<u>~</u>	The ate h page	Con			,			performe 1 □ Yes 2	od? deati	
Division of Vital Records,	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medic examiner?			Oth		ath (Check only one)		
<del>_</del>	hysi this c	၉	1 ☐ Yes 2 TNo	Hospital: 100 Inp		The second second	4 🗀 Nursing r	lome 5 ☐ Residen 28d. Describe how		Specify)
Z C	ding P	ion	27. Manner of Death  1 Natural 5 □ Pend	/A fonth	Day Year) Injury	Wor	k? Yes 2 □ No	200, 2000,20 1101	injury occurred	
isi	or Attending after death. Director: Afte in by the fune	fical	3 ☐ Suicide 6 ☐ Could	d not be 28e. Place of	Injury - At home, larm, s					r Rural Route Number,
≧	after Dire	Certification;	4 ☐ Homicide detel	building	, etc. (Specify)			City or Town,	State)	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certify	ing Physician: To the b	est of my knowledge, dea is of examination and/or i	th occurred at the tin	ne, date and place	, and due to the cau	ise(s) and manne	r as stated.
	he Ho in 24 he Fu	edical	(Check only 2 Medics one)	and manne						
	To the within 2 To the comple	Σ	29b. Signature and title of certif	ier = of D	, 1. 0	29c. Licens	e number	290	d. Date signed (M	onin, Day, Year)
			- Ture M	are th	an (M.D.	- 1	16416	,	may	18, 2005
	10		30 Name and address of perso	n who completed cause	ol death (Item 23a) (Type	Print	1	X 11	~ 0 m H	un all
			31. Date filed (Month, Day, Yea	(17) 32. Page	istrar's Signature	U Jenner	Jivama	that he	1501218	21747
	Sta Regist		MAY 2	0 2005	home de s	foods	4		V	21/10

			For State Registrar	/Final halis in a				rtment o		eath	0 Date : ( )	Reg. No.	2005	18719
п	Physicia		1. Decedent's Name MARGA	(First, Middle, La RET E .							2. Date of D		200 <sup>Y</sup> 5 <sup>ar</sup>	3. Time of Death 10:30 AM
	/Medic Examin				re street and number	)				ocation of Death			County of Deat	
			COLLEGE			22 (la um la	at hirth day.	FRE		RICK If Under 24 Hrs.	O Data of B		FREDER	
	Funeral Director		5. Social Security No. 526-30- Usual Residence of	7966	Sex 7. A	ge (In yrs. la:	Yrs.		ays	Hours Min.	8. Date of B (Month, D MAY	19 19	17	nplace (State or Foreign untry) CANADA
	aryland show	_	10a. State	10b. County	MEDV		Town or Loc							10d. Inside City Limits
	the M	recto	MD 10e. Street and Num	MONTGO	MEKI	נט	ICKER	SON 10f. Zip Co	ode			10g. Citi	izen of What Co	
	238 o	raiD	22310 M	T. EPHF	AIM ROAI	)		2084					SA	
920	urs after des at', or iteme Ter iner m	by Fune	<ul><li>11. Marital Status</li><li>1 ☐ Never Marrio</li><li>3 ☑ Widowed</li></ul>		12. Was Deceden Armed Forces 1 Ves 2 If Yes, Give Year or Dates	? <sup>]No</sup> 195(	<b>1</b>	Vas Decedent Yes, specify  Yes 2	/	panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes <i>o</i> r N Rican, etc.)	lo-	14. Race - Ame Black, White Specify: W:	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 21a or 28a-f show any Injury or other traumatic event, It a Madical Examinar must be notified at once.	Completed by Funeral Director	(Speci	15. Decedent's E fy only highest gi ndary (0-12)	ade completed) College (1-4o	5+)				ion ring most of work	ing	NA'	ind of Business/	INSTITUT
Maryland 2	uld be filed v Aental Hygie rked other i tic event, tt	To Be Co	17. Father's Name (		5+ EACRET	?	NURS	ING D	1	ECTOR 18. Mother's Nam ALMA C		e, Maiden		••
, Mary	and 2 short alth and No. 27 is ma		19a. Informant's Na		• •					CT., A				<sup>(ip Code)</sup> 1710
Baltimore,	Pages 1 and the court of He court of He court: If item rry or other		20a. Method of Disp 1 Burial 2 4 4 Donation	Cremation 3 [	Removal from State	20b. Pla cer FRE	ice of Dispos metery, crem EDERI	sition (Name of atory or other CK CR	of or place) EMA	T. 5/2	Date 3 / 0 5		ocation - City or T	
Balti	permit. Departrimporta Importa any Inju		21. Signature of Fu	Sprvite Lice	hselp		H	Name and A	FU	of Facility INERAL 86, BA	HOME			20838
	hysician /Medical Examiner		23a. Part1. Enter the shock, or hear Immediate Cause (disease or condition resulting in death)	Final	nplications that cause one cause on each a	^	Do not ente	or the mode o	of dying,	such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
		Examiner	Sequentially list cor if any, leading to his cause. Enter Under Cause (Disease or that initiated events	nditions, me diate lying njury	b. Due to (or a	a a conseque	ance of):							
	ate be executed hysician and the burial-transit	Icai	resulting in death) L	ast	Due to (or a	s a conseque	ence of):							
.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 1  Yes 20 9 Unknown	months?	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal d	leath 3	Ectopic pregr Other (specia				2	23d. Date of deli Month	very Day Year
ds, P	signed b	þ			contributing to death	but not result	ting in the un	derlying caus	se given	in Part I.			1	the cause of death?
	The lar ate has page 2	Completed										s an opsy formed? 2 No		topsy findings available completion of cause of
Vital	Phyeiclan: this certific ral director,	Be	25. Was case referr examiner?	ed to medical	Hospital:					26. Place of Deat	h (Check only	one)		
o	<u>&gt; .º</u> 0	on: To	1 ☐ Yes 2 27. Manner of Death 1 ☑ Natural		28a. Date of In (Month, D	jury 2	R/Outpatient 28b. Time of Injury	28c.	Other Injury a Work?	Nursing Ho	ome 5 Res 28d. Describe		6 □Other (Spec y occurred	enfy)
	Attencer death ector:	Certification:	2 Accident 3 Suicide 4 Homicide	investigation 6 Could not lidetermined	28e. Place of I	njury - At hometc. (Specify)	ne, farm, stre	M et, factory, of		es 2 No		(Street an own, State		ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only one)	1 Certifying P	hysician: To the bes miner: On the basis and manners	of examination	ledge, death on and/or inv	occurred at t estigation, in	the time my opir	, date and place, nion, death occur	and due to the red at the time	e cause(s) , date and	and manner as I place, and due	stated. to the cause(s)
1	To th To th compl	Me	29b. Signature and	title of certifier	Shah t	G. V.			icense			29d. Dat	e signed (Month	n, Day, Year)
1	2		30. Name and addre	ess of person who	completed cause of			Print)	ν <sup>.</sup> S	7643.		11/14	4 00, 5	XCO2
1	-			-11	~			_		. 0	. ^	2		

DHMH 17 Rev 1/2001

			4 101	ndelible ink. Ensure Alpartment of Health and Nertificate of Death	•	ne 2005 (27)
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last)  Wendy Michele Lyons 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	2. Date of Death Month May	Day Year 26 2005 3:22 P M 4c. County of Death
	Funeral Director		Frederick Memorial Hospital  5. Social Security Number  5. Social Security Number  6. Sex  1 M 2 K 7. Age (In yrs. last birthda  8. Sex	Months Days Hours Min	8. Date of Birth (Month, Day, Ye. Nov 19,	Frederick  9. Birthplace (State or Foreign Country) Virginia
	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. It marked other then "naturel", or Items 23a or 28a-f show umatic event. The Medical Exercitat for motified at	ector	10a. State 10b. County 10c. City, Town or	Location nt Airy 10f. Zip Code	100	10d. Inside City Limits 1 □ Yes 2 √√√√√√√√  Citizen of What Country?
	s 23a or	erai Dir	13526 Penn Shop Road	21771		U.S.A.
900	ours after de irel', or Item Examinetre	d by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto     □ Yes 2♥ No Specify:	ecity Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-4 show any injury or other traumatic event, the Madical Examinating the prolities of an once.	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of work n. DO NOT use retired) IOMEMAKET	ing 16b	. Kind of Business/Industry Own Home
yland	ould be file Mental Hy arked oth atic event	To Be (	17. Father's Name (First, Middle, Last)  Clifford Harvey	18. Mother's Name Kather	e (First, Middle, Maid ine	<sub>den Sumame)</sub> Parker
	and 2 sho salth and n 27 is mu			illing Address (Street and Number or Rur. 26 Penn Shop Road,		
Baltimore,	Pages 1 nent of Ho ent: If iter ury or oth		1 Rurial 2 XI Cremation 3 Removal from State	position (Name of rematory or other place) arg Crematory May		Location - City or Town, State Smithsburg, MD
Balt	permit. Departi Import any inj		21. Signature of Funeral Service Oceasee  Chippe Karacana M00706	22. Name and Address of Facility Keeney & Basford F 106 East Church St,	'.A. Funer. Frederic	al Home k, MD 21701
	Pnysician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not deshook, or hear/failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	enter the mode of dying, such as cardiac o	or respiratory arrest,	Approximate Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to in injection cause. Enter Underlying Cause (Olsease or injury)	n A	Figure D.	tred 4days
760,	eath certificate be executed attending physician and for use as the burial-transit	Icai Examiner	that initiated events resulting in death) Last  C.  Due to (or as a consequence of):  d.	Certifica Row	ation M.D. ser, al Exa	ME
P.O. Box 68	To the Hospitel or Attending Physiclen: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending pheomptelety filled in by the funeral director, page 2 should be detached for use as it.	Physician/Med		B Ectopic pregnancy		23d. Date of delivery Month Day Year
rds, P.	n requires that the de been signed by the should be detached	ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the DEPRESSION	underlying cause given in Part I.		to use contribute to the cause of death?
Vital Records,	: The taw recate has been page 2 sho	Completed by			24a. Was an autopsy performed?	
	Physiclen: The this certificate had director, page	To Be	25. Was case referred to medical examiner?  1 [XYes 2 ] No	Other	me 5 Residence	6 ☐ Other (Specify)
Division of	ending Ph aath. or: After th he funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  5 22 05		28d. Describe how in Self In	flicted Hanging
DIX	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	Certification:		spital	City or Town, Sta	Irederick Memorial
	he Hosp n 24 hou he Fune pletely fil	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
)	To t withi To t	×	29b. Signature and title of certifier M.D.	29c. License number 000 \$ 5 79 3	29d. E	Date signed (Month, Day, Year) $S/27/05$
	3		30. Name and address of person who completed cause of death (Item 23a) (Typ	Frederick Memorial H	ospital	
	Sta Registr		31. Date filed (Month, Day, Year)  32. Begistrar's Signature	caste)		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Year **Physician** May 28, 2005 Mary Logsdon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frostburg Allegany Frostburg Village Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Mar 18, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1910 1 □ M 2 🛛 F MD 557-70-8995 95 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits itam 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Exertance for must be mailted at MD Allegany Cumberland Director 1 ☐XYes 2 ☐ No 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 701 Furnace Street Apt. 21 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 72 hours after ☐ Yes 2 No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white ģ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 72 th and Mental Hyglene. 7 Is marked other than "ne College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Burkey Nellie (Schilling) Burkey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s if Health an 714 Adams Avenue William Logsdon son Cumberland MD 21502 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If its
any injury or ot St. Patrick's Cemetery 5/31/2005 MD Cumberland 4 □ Donation 5 □ Other (Specify) <sup>22. Name and Address of Facility</sup> Scarpelli Funeral Home, P.A 21. Signature of Funeral Service Licensee 108 Virginia Avenue; Cumberland, MD 21502 the fibe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate cause (Final disease or undition Priysician emen eav5 /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner use as the burial-transit iding physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant the atter 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year Month 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 3 Probably 1 Tes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 **1** No 2 🗆 No 1 ☐ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 4 V Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 2 ER/Outpatient 3 DOA his 27. Manyer of Death 1 Watural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of of or Attanding Parties death, Certification: 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D144 64 05-28.2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.L. Sandhir M.D 31. Date filed (Month, Day, Year) 48 Tarn Terrace Frostburg MD 21532 Registrar's Signature State JUN 0 3 2005 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 200 XX /Medical Beulah Leota Murray Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 'acred 8. Date of Birth (Month, Day, Year If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2 X F Yrs. Director 27, Maryland Feb. 159-12-9881 92 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Medical Examinar r-wat be molified at 1 ☐ Yes 2 🔀 No Director Grantsville Maryland Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21536 **USA** 12408 National Pike 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎇 No Specify: White by 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) s 1 and 2 should be fill f Health and Mental H Item 27 le marked oth Be Mertie Otto Floyd H. Broadwater 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10882 National Pike, Grantsville, MD Charles R. Murray, Son Item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. = 5 Grantsville Cem, May 25, 2005 Grantsville, MD 21536 ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A., 21. Signature of Funeral Service Licensee lessale 179 Miller St, PO Box 275, Grantsville, MD 21536 23a. Part1. Enter the cisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he art finiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** 5 DAYS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner death certificate be executed burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ö Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f o 9 Unknown 9 Unknown ۵. signed by be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ INFECTION 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an , page 2 s has certificate 2 TO No 1 ☐ Yes director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral of 27. Manner Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; Hospitel or Attending 1 Unatural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined within 24 hours after dea To the Funeral Directo completely filled in by th 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier l 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier

State Registrar

addres

Loveria 31. Date filed (Month, Day, Year)

Name and

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DHMH 17 Rev 1/2001

Germa II Spark

Cumberland MD 21502

erson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

			For State Registrar	State o	of Maryland		artment of F		nd Mental Hy	/giene Reg. No.	2005	18723
Г	Physici	an	1. Decedent's Name (First, Mide Kath leen	0 1	40 5				2. Date of D Month	eath Day	Year	3. Time of Death
1	/Medic	al	4a. Facility Name (If not instituti	Bagby	Maia		4b. City, Town, o	r Loostion of	05	18	2005 County of Death	01:08 AM
	Examin	ier	University of	Mary/gad		Center		flmore				re City
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. Ia		If Under 1 Year Months Days	If Under 2		rth		place (State or Foreign
	Director		577-96-6588	1 ☐ M 2 🔀 F	51	Yrs.	Months Days	Hours	Aug. 2	2, 19	53 Cali:	fornia
	and and		Usual Residence of Decedent 10a. State 10b. Count	ty	10c. City,	Town or Lo	ocation					10d. Inside City Limits
	Mary -f sh	tor	Maryland Fred	erick	M-	yersv:	i11e					1 ☐ Yes 2 🔯 No
	th the	Director	10e. Street and Number	or row		yersv.	10f. Zip Code			10g. Citiz	en of What Cou	ntry?
	ours after death with the Marylan rat', or itams 23e or 28e-f show Examiner must be notified at		3909 Highlan	d Avenue			21	773		Un	ited Sta	ates
	er de:	Funeral	11. Marital Status	Armed Fo		. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Orig an, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	0- 1-	<ol> <li>Race - Americal Black, White,</li> </ol>	
36	irs aft	by F	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 【※ Divorce	If Yes Gi	ve		1 ☐ Yes 2 🔀 No	Specify:			Specify: [	Vhite
9	2 ho			ent's Education			dent's Usual Occup		-6	16b. Kin	d of Business/In	dustry
21	Jwithin 7 giene. r than "n Ire Medi	Completed	Elementary/Secondary (0-12)	nest grade completed)  College (	1-4or 5+)	life.	kind of work done of DO NOT use retired	d)	or working			
121	filed w I Hygier other th		12 17. Father's Name (First, Middle	2 ( 201)		Nurs	ses Aide	10 Mother	's Name (First, Middle		ursing H	Home
Maryland 21215-0036	be od o	Be	Allen Bagby	s, Last/							sumame)	
Z Z	2 should be and Mental is marked sumatic av	L C	19a. Informant's Name/Relation	nship (Type, Print)		19b. Mailir	ng Address (Street		ene Castoi		Town, State, Zip	Code)
	and 2 lealth a m 27 is		Bryan A. Main	/ Son		11 C1	coss Laur	el Cou	ırt Germa	antown	n, Maryl	and 20876
ore	ita ita		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation	3 Removal from	0.00	ice of Dispo	sition (Name of matory or other plac	(e) M	Date	20c. Loc	ation - City or To	own, State
Ĕ	Pages ment of tant: If its		'4 □Donation 5 □ Other	(Specity)			Cremato		lay 23, 2005	Frede	rick, M	aryland
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Sign ture of Funeral Service	e Licensee		22	2. Name and Addre	ss of Facility	Stauffer	Funer	cal Home	es, P.A.
	45200		23a Part1. Enter the disease	o complications that	caused the death						ck, Mary	land 21702
la la			23a. Part1. Enter the disease, shock, or heart failure. Litemmediate Cause (Final							inost,		Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	aDue to	(or as a conseque	ence of):	1 Hem	orrho	ig e		-	
E	Examiner		Sequentially list conditions,	b								
	pe tis	iner	if any, leading to immediate cause. Enter Underlying		(or as a conseque	ence of):						
	be executed sician and burial-transit	Examine	that initiated events resulting in death) Last	c	(or as a conseque	ence of):						
8760,	ate be executed hysician and the burial-transit	dical E			,	,						
9	tificate ng phys as the	0										
Вох	death certifics e attending ph od for use as t	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		tcome of pregnand pirth 2 - Fetal d		Ectopic pregnancy	,		23	3d. Date of delive	,
0	the all	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregr 9□ Unkn	nant at time of dea own	ath 5□	Other (specify)				Month	Day Year
۵.	that the died by the detached		Part II. Other significant condi-	tions contributing to d	eath but not result	ting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco us	e contribute to the	ne cause of death?
rds,	es igr be	d by							1 🗆	Yes 2	No 3 ☐ Prob	oably 4 Unknown
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/ita	ysician: Th is certificate director, pag	Be (	25. Was case referred to medic examiner?						of Death (Check only			
of Vital Record	6 0 E	٦-	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Z		R/Outpatien 28b. Time of	t 3 DOA Oth	4 🗀 (40)	sing Home 5 Res			iv)
	fter fter	tlon	1 ZNatural 5 ☐ Pend		th, Day Year)	Injury	Worl	k? Yes 2 □N	28d. Describe	now injury	occurred	
Division	Attending r death. ector: After by the fune	ifica	3 Suicide 6 □ Could	d not be	of Injury - At homing, etc. (Specify)	ne, farm, str	eet, factory, office				Number or Rura	il Route Number,
Ö	tal or A rs after al Dire ed in by	Certification;	4   Homicide	Duka	ing, etc. ( <i>apecily</i> )				City or Te	wn, State)		
	To tha Hospital or Attendi within 24 hours after death. To tha Funaral Director: A completely filled in by the to	edical	29a. Certifier Check only one) Certify		asis of examination ner stated.	on and/or inv	vestigation, in my o	pinion, death	occurred at the time,	date and p	place, and due to	the cause(s)
	To tha within 2 To tha complet	Ž	29b. Signature and title of certif	ier			29c. License	e number		29d. Date	signed (Month,	Day, Year)
					np		15	817		05/	18/2	005
	10		30. Name and address of perso	n who completed caus	se of death (Item 2	23а) (Туре,	Print)	R - 131 -	note, Mory	1-	1 21	20/
	Sta	te	Zouis Chan 31. Date filed (Month Day, Yea	g, 22 5.	Registrar's Signatu	re .	- IreeT	1201110	ione polary	1/54	a	/
-	Registr		31. Date filed (Month, Day, Yea	3 2005	home d	· Con	and of					

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		•	For State Registrar	Otato of	Marytai	•	rtificate of			g. No.2 0 (	)5 18	724
	Obvolsi		1. Decedent's Name (First, Middle,	Last)				-	2. Date of Death Month		Year 3. Time	e of Death
	Physici: Medic/		Gwendolyn	Ka:		N	<u>CEntire</u>		May 2	4, 200	5 6:5	Oam <sup>™</sup>
	Examin	er	4a. Facility Name (If not institution,		ber)			or Location of Death dsboro	1	4c. County o	erick	
-	uneral		322 Copper Oak 5. Social Security Number 6		'. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthplace (Star Country)	te or Foreign
	irector		162-42-3167	1 □ M 2 <b>/□</b> MF	5	6 Yrs.	Months Days	Hours Min.	Oct 31,	1948	Pennsylv	ania
and	M. I		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation				10d. Inside	City Limits
Mary	-f sho	to	Maryland Freder	rick		Wood	sboro				1 🗆 Y	es 2 ₹No
th the	or 28a	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of W	-	
d 21215-0036 filed within 72 hours after death with the Maryland Hydiane	s 23a	rai	322 Copper Oaks					21798			S.A.	
ler de	Items Items	Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☑ Married</li></ul>	12. Was Deced	ces?	J.S. 13.	Was Decedent of I If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- p Rican, etc.)		<ul> <li>American Indian</li> <li>White, etc.</li> </ul>	l,
<b>036</b> urs af	P G	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dai			1 ☐ Yes 2 ☐ No	Specify:		Specify:	White	
<b>5-0</b>	netur	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece	dent's Usual Occup kind of work done	oation during most of wor d)	king 1	6b. Kind of Bus	siness/Industry	
within	then '	ldm	Elementary/Secondary (0-12)	College (1-	4or 5+)		iter/Edit			Public	cations	
Hygie	other ent. II	Be Co	17. Father's Name (First, Middle, La	ist)				r -	ne (First, Middle, M			
/lan	rked tic ev	To B	Odell Jeni	nings	Sha	nk		Yula	Kath1	.een	Null	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mantal Hyolene	Important: If term 27 is marked other then "neturel", or Items 23a or 28a-f show any injury or other traumatic event. If a Medical Examinating the Intiliard at once.		19a. Informant's Name/Relationship		•				ral Route Number,	-		700
e, V	em 27 ther t		Thomas S. McEnt:	ire/Husba	20b. I	Place of Dispo	osition (Name of		, Woodsbo		cy Land 21 City or Town, State	
Pages	t: H it y or o		1 ☐ Burial 2 Table remation 3	Removal from S	tate	cemetery, cre	matory or other pla	·	28, 2005			
Baltir permit. P	ortan injur		21. Sign. tur a of Funeral Service Li		_   5111	2:	2. Name and Addre	ss of Facility				
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Ţij.			23a. Part1. Enter the disease, or co shock, or hear railure. List or	omplications that ca nly one cause on ea	used the dea	th. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory arre	st,	Approxir Interval I	nate
E .	sician		Immediate Cause (Final disease or condition resulting in death)	a Bra	ain Me	tastas	es				1 mor	_
	ledical aminer		resulting in dealth)		r as a consec		6592				12	*-la-a
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		east Consec	arcino	llid				12 mc	ontris
Cuted	nd ransit	Examiner	Cause (Disease or injury that initiated events	с.							J	ŧ
of Vital Records, P.O. Box 68760, 5- Physician: The law requires that the death certificate be executed	rsician and e burial-transit	cal Ex	resulting in death) Last	Due to (o	or as a consec	quence of);						
687 tifficate		dice		d						111		
Box (	attending phy I for use as the	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc			7F-t-nio assaula			23d. Date	of delivery	
G deat	he atte	sicla	in the past 12 months?		th 2∏Feta int at time of o wn		□Ectopic pregnanc □ Other (specify) _	у		Mon	th Day	Year
P.O.	ed by the detached	Phy	9 Unknown  Part II. Other significant condition			sulting in the t	inderlying cause giv	ven in Part I	23e. Did toba	acco use contri	bute to the cause of	of death?
ds,	signe d be d	d by	Faith, Other signment conducti	o continuating to det	atir but not re-	salang ar are c	andenying cause gi	roll art art i.			3 ☐ Probably 4	
W req	ias been signed t s 2 should be det	Completed							24a. Was an	24b. W	ere autopsy findin	gs available
Re la	te has age 2	omp							autopsy perform	ed? de	rior to completion death? □ Yes 2 □ No	of cause of
ian:	is certificate ha director, page	BeC	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only one			
of V	this ce al dire	၉	1 ☐ Yes 2 🙀 No			ER/Outpatie	III JU DOA	TO STATE OF THE ST	ome 5 Resider			1
on o	After	tion:	27. Manner of Death  1   Natural 5 □ Pending 2 □ Accident investiga		, Day Year)	28b. Time o Injury	Wo	ryat rk? ]Yes 2 ∐No	28d. Describe how	v injury occurre	ia .	
Division of Vital Record I or Attending Physician: The law requir after death.	actor: by the	Certification:	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place of	of Injury - At h	nome, farm, st	reet, factory, office	<del>-</del>	28f. Location (Stre	et and Numbe	r or Rural Route N	lumber,
Div tal or	al Dir	Cert	4 Homicide	Dulidin	g, etc. (Speci				City or Town,	State)		
Hospi 4 hour	Funer ely fill		(Check only 2 Medical E	Physician: To the to	sis of examina							e(s)
Div To the Hospital or within 24 hours afte	To the Funeral Director: After this completely filled in by the funeral di	Medical	one) 29b. Signature and title of certifier	and mann	er stated.		29c. Licens	se number	29	d. Date signed	(Month, Day, Year	r)
¥ 3	: F= 8			~		men	D14	626		May 24		
	,		30. Name and address of person w	no completed cause	of death (Ite	m 23a) (Type,	, Print)					
10:	6		P. Gregory Rau				Seventh S	treet, Fr	ederick,	Maryla	nd 21701	
	Sta Registr		JUN 0 3	2005 32 Re	gistrar's Sign	ature &	ulis					
		-31	O O NIOG		West of	/* A/54						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mattenth26, 1:24 AM M **Physician** Mary Ellen Moore /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carroll Continuum Care at Sykesville Sykesville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign | Months | Days | Hours | Min. | Sept. 15, 1938 | Washington, D.C. 7. Age (In yrs. last birthdav) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🔀 F 578-50-0844 66 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County 28a-f show the Medical Examiner must be notified at Sykesville Yos 2 No Maryland Carroll Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 21784 7309 Second Ave. U.S.A. "natural", or Items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. I be important: If item 27 is marked other than "natural", or the any injury or other traumatic event 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: Specify: White þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cook/Waitress Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Helen Irene Crown William Andrew Moore ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5615~Old~Oak~Drive,~Mt.~Airy,~MD~2177119a. Informant's Name/Relationship (Type, Print) William E. DeLacerda, son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Smithsburg Crematory May 27, 2005 Smithsburg, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Keeney and Bastord PA Funeral Home Duce Richard 106 East Church St., Frederick, MD 21701 M00255 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine signed by the attending physician and the detached for use as the burial-transit be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 2 □ No 3 □ Probably 4 □Unknown 1 Yes Completed been 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this nours after death.

neral Director: After this

filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28b. Time of Certification: 1 Natural 5 Pending 1 Tyes 2 No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 THomicide To the Hospital o within 24 hours aft To the Funeral Di 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 51705 30. Name and address of person who completed cause of death (Item 23a) (Tyge, Print) Westminster 349 PANSURIYA malaim 31. Date filed (Month, Day, Year) State JUN 0 3 2005 Registrar

			i icase i	State of Marylan				_	•	
		-	For State Registrar	State of Marytan		ficate of i			eg. No. 2005	18726
			Negistrar     Decedent's Name (First, Middle, Last)		00/11	770010 07 1	Joann	2. Date of Dear	-	3. Time of Death
	Physicia		Ollie Cant	rude N	aller	1		Month May 15	Day Year 2005	5:00 A M
	/Medic		4a. Facility Name (If not institution, give st				r Location of Death	1147 12	4c. County of Death	3.00 11
	Examin	er	209 Munroe Avenue	,		Edgewat			Anne Arund	le1
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		place (State or Foreign
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	D >		Usual Residence of Decedent  10a. State 10b. County	10c Cit	y, Town or Loca	tion				10d. Inside City Limits
	sho	'n	,			don				1X Yes 2 □ No
	the N	Director	Maryland Anne Arune	der rag	ewater	10f. Zip Code		1	0g. Citizen of What Cou	ntrv?
	with a or		209 Munroe Avenue			21037			JSA	
	ne 23	Funeral		2. Was Decedent Ever in U.	S. 13. Wa		lispanic Origin? (Spe an, Mexican, Puerto		14. Race - Ameri	
ယ	after or Iter	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give				Rican, etc.)	Black, White,	etc.
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21215-0036	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do thygiene than "natural", or Iteme 23a or 28a-f show event, the Madical Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade		(Give kir	nt's Usual Occup	during most of worki	ng	16b. Kind of Business/Ir	dustry
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5	filed withi Hygiene. other than ent, the M		17. Father's Name (First, Middle, Last)		Home	Maker	18. Mother's Name	(First, Middle,	Own Home Maiden Sumame)	
an	ould be Mental larked o	o Be	John C. Abell				Jane Joy			
Maryland	2 should be and Mentary le marked raumatic ev	<sup>L</sup>	19a. Informant's Name/Relationship (Typ	ne, Print)	19b. Mailing	Address (Street		l Route Number	r, City or Town, State, Zij	o Code)
	d 2 tra		Irene Harris/ Daug	hter	3534 S	outh Ri	ver Terra	ce Edgev	vater, MD 21	.037
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.	F	20a. Method of Disposition	20b. F	Place of Disposit emetery, crema Ft	ion (Name of tory or other plac		ate	20c. Location - City or T	own, State
E	Page nent c int: If	hţ	1 ☐XBurial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Cemet	Lincol:	n 5/19	/2005 I	Brentwood, N	ſD
alti	permit. Departminimports mports any inju		21. Signature of Funeral Service License	9	22. 1	Name and Addre	ss of Facility Ro	oert E.	Evans Funer	al Home
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н			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the deat e cause on each line.	h. Do not enter	the mode of dyir	ng, such as cardiac o	or respiratory arr	est,	Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	0				
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	ted nsit	nin	Faquentially lict conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exerts.	Temen	ntia					
	be executed sician and burial-transit	Examine	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):					
760,		cail	d							
68	leath certificate I attending physi									
Вох	ih cer endin r use	N/us	23b. was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		ctopic pregnancy	,		23d. Date of delive	ery Day Year
	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	in the past 12 months? 1 Tyes 2 No	4 ☐ Pregnant at time of d 9 ☐ Unknown		Other (specify)			WORTH	Day Teal
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	signed be del	by	Part II. Other significant conditions con	mouning to death out not res	alang in the and	erlying cause giv	en in Fait i.			bably 4 DUnknown
Records,	w require been si should I	Completed						ļi		
3ec	has the	mpi						24a. Was a autop perfor	sy prior to co	opsy findings available ompletion of cause of
a	yeicien: The is certificate ha							1 Yes	2 ☑ No 1 ☐ Yes	2□ No
Vital	Physicien: this certificaral director, I	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ ₩6	ospital:	CR/Outpatient	3□ DOA Oth	26. Place of Deatl		ence 6 □Other (Speci	f()
of	P = F	li Hill	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injui			ow injury occurred	197)
lon	Attending Ph r death. ector; Atter th by the funeral	ation	1 Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury		Yes 2 □ No			
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	tel or rs afte el Dir	Cert		, , , , , , , , , , , , , , , , , , , ,			,	,		
	To the Hospitel or Attent within 24 hours after death To the Funerel Director; completely filled in by the	Medical Certification;	(Check only 2 Madical Examin	sician: To the best of my kno ner: On the basis of examina						
	thin 2 the mplet	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number	2	29d. Date signed (Month,	Day, Year)
	1 × 1 8		· CHaller	l_			56826		Slicher	
,			30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type Pi	rint)	00.16	U.S	مارماس	
			207 Ridaelu	1 Are A	nnap	allis 1	MD 2	1401		
	Sta	ate	31. Date filed (Month, Day, Year)	32 legistrar's Signa	ature			101		
	Regist	rar	WAY 18 200	15 Bow A	S AN					

within 24 hours a To the Funerel L 0

State

DHMH 17 Rev 1/2001

Name and addres of person who completed cause of death (Item 23a) (Type, Print) MARYBRITA 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Minee

32

29c. License number

OCME

111 Penn Street

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21201

May 14, 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Clark Eugene Resh /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner umberiar tt Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 12,1918 Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) **Funeral №** M 2□ F Months 213-12-9590 86 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic evant, the Mudical Experiment dust be notified at Director 1 ☐ Yes 2 X No Garrett Grantsville MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Items 23a 2111 Jennings Road 21536 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: f Yes, Give Year or Dates: 3 □ Widowed 4 □ Divorced White 'natural', 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Pulverizer Oper. & Power Press 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) Fire Brick Manufac. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F Pages 1 and 2 should be Orvis Resh Nora Bittinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if of Health a Duella Resh/Wife 2111 Jennings Road, Grantsville, MD 21536 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State ō permit. Page Department of Important: If any injury or once. Grantsville Cem. May 23,2005 Grantsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, 21. Signature of Funeral Service Licensee amau P.O. Box 275, Grantsville, MD 21536 04 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or least failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Bstructive Pulmonary **Examiner** monico Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed the burial-transit Cosis 5/1 that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. | the 9 Unknown 23e. Did tobacco use contribute to the cause of death? to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown filled in by the funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural Injury 5 Pending after death. investigation 1 🗌 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a a Funaral I 29a. Certifier 📂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho To tha Funa completely 1 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To tha 29c. License number 29b. Signature and tille of Certifier 29d. Date signed (Month, Day, Year) 2005 M1) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. NARAL SAhetA Memoria State Registrar

			1 - For State Registrar	State of Maryland	/ Depa	artment o	f Health and of Death	Mental Hyg	_	005		721
	Phỳsici	an	Decedent's Name (First, Middle, Last,					2. Date of Dea Month	th Day	Year	3. Time of	f Death-
	/Medic		Mary Louis					May 2	0, 2	005	2:15	P M
	Examir	er	4a. Fecility Name (If not institution, give		1	•	n, or Location of Dear	h		ty of Death	_	
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K. 100	Funeral Director			7. Age (in yrs. las	Yrs.	Months Da			, Year)		olace (State ontry) yland	
	yland yland		10a. State 10b. County	10c. City, 1	Town or Lo	cation					I0d. Inside C	ity Limits
:	a-fa	ctor	Md. Frederi	ick M-	i dd 1 e	etown					1 🖺 Yes	2 No
	or 28	Director	10e. Street and Number			10f. Zip Cod		1	0g. Citizen of	What Cou	ntry?	
	23a		6600 Roy Si	nafer Road		21	769		uSA			
	ours after death with the Marylan rat', or thems 23a or 28a-f show Examinet must be notified at	Funeral		12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent Yes, specify C	ol Hispanic Origin? (S Juban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Ra Bla	ice - Americack, White,	can Indian, etc.	
36	I', or		1 Never Married 2 Married  3  Widowed 4 Divorced	1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates:	1	☐Yes 2🏋	No Specify:		Speci	ify: Wh:	ite	
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9	be filed within 72 ha ital Hygiene. id other than "natul event, the Madical	Be C	17. Father's Name (First, Middle, Last)	_			18. Mother's Na	me (First, Middle, i		m <i>e)</i>		
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Maryland	d 2 should th and Mer 7 is market traumatic		19a. Informant's Name/Relationship (Ty		19b. Mailin	g Address (Str	eet and Number or R	ural Route Number	r, City or Town	n, State, Zip	Code)	
	s 1 and f Health Item 27 other tr		Gary D. Rice				y Rd. Mi					
Baltimore,	e = 5		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ P	lemoval from State	netery, crem	sition (Name of natory or other	place)		20c. Location			
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g D	Department Page Manager Page Page Page Page Page Page Page Page		21. Signature of Funeral Service License Dand L. Stock	2,6. 4m01035	Но	me,31	E. Main	nald B. St.Mid	dleto	pson wn.Mo	Fune	ral
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)		d c		dying, such as cardia	4.5			Approximat Interval Bet Onset and I	tween
4.	be executed cian and burial-transit	cal Examiner	Sequentially list conditions, if any, Lading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer								
, P.O. Box 68/	rial the death certifical ed by the attending ph detached for use as the	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 D No 9 Unknown	3c. If yes, outcome of pregnanc 1	eath 3 th 5	Ectopic pregna Other (specify derlying cause	)	23e. Did tot		ate of delive onth	Day h	Year death?
ras	n sign	q p						1 □ Ye	s 2 No	3 ☐ Prob	ably 4 🗆	Jnknown
		Completed						24a. Was a autops perforr	y I	Were auto prior to cor death? 1 \( \text{Yes} \)	psy findings mpletion of c	available ause of
or Vital	certificate rector, pag	Be (	25. Was case referred to medical examiner?					ath (Check only on	в)			
0	this o	ို	1 195 2 2 240		VOutpatient	3 DOA		lome 5 PReside			v)	
	r death. ector: After by the funera	Certification:	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day Year)	3b. Time of Injury	\	njury at Work? I □ Yes 2 □ No	28d. Describe ho	ow injury occu	rred		
= 7	rs after d al Direct ed in by (	Certifle	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	eet, lactory, offi	се	28I. Location (St. City or Town		ber or Rura	il Route Num	ber,
200	to the mapping of Assenting within 24 hours after death.  To the Euneral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Examination	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the estigation, in m	e time, date and place by opinion, death occu	e, and due to the carried at the time, da	ause(s) and m ate and place,	anner as si and due to	ated. the cause(s	1)
-	To the complete of the complet	Σ	29b. Signature and title of certifier			29c. Lici	ense number	2	9d. Date signe			
			NO COLE			D	35695		5.2	3.05		
	3			mpleted cause of death (Item 23			Thema PREDER	s 704.	isan	D		
4	Sta Registr		31. Date liled (Month, Day, Year) MAY 2 3 20	32. Fegistrar's Signature	0	F	PREDERI	Cle in D	21	762		

			1 - For State Registrar	State of	f Marylan	•	artment rtificate				lental Hy	giene	111	05	18	730
	Dhucisi	an	1. Decedent's Name (First, Middle	e, Last)							2. Date of De	eath Da	ıy	Year	3. Time	
	Physici /Medio		Ida Marie Renn			,						8, 2	005		8:00	Рм
	Examir	ner	4a. Facility Name (If not institution	n, give street and num	nber)				Location of	of Death		40	. County			
			College View 5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday	Fred If Under	deri	ck If Under	24 Hrs	8 Data of Bi	rth		deri		or Formion
	Funeral Director		220 <b>-</b> 48 <b>-</b> 3927	1 M 2 M F	101	Yrs.		Days	Hours	Min.	8. Date of Bi (Month, D. March	ay, Year	904	Mary	place (State intry) 1 and	or Foreign
			Usual Residence of Decedent		101			l			narch	22,1	704	ini y	- Land	
	nyland how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation								10d. Inside (	
	Ba-f s	cto	Maryland Frede	rick	F <sub>1</sub>	rederio	k									3 2 □ No
	vith th	Dire	10e. Street and Number				10f. Zip					•	tizen of W		•	
	s 238	Funeral Director	920 Gas House		dent Ever in U	C 12		701	anania Ori	sin2/Cod	oifu Voo or N		ted S		es can Indian,	
	ter de	-L	11. Marital Status 1 □ Never Married 2 □ Married	Armed Fo	rces?	.3.	f Yes, speci	ify Cubar	n, Mexicar	n, Puerto	ecify Yes or Na Rican, etc.)	0.		k, White		
036	urs al	<b>A</b>	3 🔀 Widowed 4 🗆 Divorced	If Yes Giv	е		1□Yes 2	!⊋ No	Specify:				Specify	Wh:	ite	
21215-0036	72 hours after death with the Maryland netural', or Itams 23a or 28a-f show dical Examilied at	Completed	15. Deceden	it's Education st grade completed)		16a. Dece	dent's Usual	l Occupa	ition	t of worki	na	16b. K	(ind of Bu	siness/l	ndustry	
21	within 7 ene. than "t	npie	Elementary/Secondary (0-12)	College (1	-4or 5+)	1	kind of world DO NOT use Make		)	L DI WOIN	,,g					
	filed with Hygiene. other than		11	(	- 100	HOME	ake	- T	10 14-15-	-d- No	/Fina 84inlell		n Hon			-
and	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle,						Lill:		) (First, Middle	э, маюн	1 Surnam	θ)		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylar nt of Health and Mental Hygiene. If item 27 is marked other than "netural", or items 23a or 28a-f show or other treumatic event, the Modical Examiner must be multipled at	ဠ	Frank B. Keefer			19h Mailir	address				u Route Numb	ner City	or Town	State 7i	n Code)	
Ma	id 2 sho		Robert E. Renn								rederio			01210, 2,	, ,	
	s 1 and Health tem 27 othar tr		20a. Method of Disposition		20b. F	Place of Dispo cemetery, crer				A STATE OF THE PARTY OF THE PAR	Date			City or T	own, State	
Ę	Pages nent of I int: If it		1 □ Burial 2 □ Cremation  1 □ Donation 5 □ Other (S			. Olive		nei piace	"	5/21,	/2005	Fred	leric	k, 1	lary1a:	nd
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or othar tre once.		21. Signature of Funeral Service	Licensee		22	2. Name and	d Addres	s of Facilit	y Sta	auffer	Fune	eral	Home	, P.A	
<b>B</b>	99 5 8		Budly f	Smeter		16	21 Op	oeeu	mtown	n Pil	ke,Fred	eric	k, M	D 21	702	
н			23a. Part1. Enter the alsevere, or shock, or he ailing. List	complications that conly or cause on e	aused the deat ach line.	h. Do not ent	er the mode	of dying	, such as	cardiac c	or respiratory a	arrest,			Approxima Interval Be Onset and	tween
	Physician		Immediate Cause (Final disease or condition	a CON	68501	5 H	EART	l L	AILL	m&					a D	AGJ
	/Medical Examiner	: 1	resulting in death)		or as a conseq		37,								1. ~	
		<u>.</u>	Sequentially list conditions,	D	or as a nonseq	A CONTRACTOR OF THE PARTY OF TH								-	TDI	447
	rted nsit	i i	Sequentially list conditions, it ary, is admit to infine detections. Enter Underlying Cause (Disease or injury	<												
Ć,	execu in and ial-tra	Examiner	that initiated events resulting in death) Last	C. Due to (	or as a conseq	juence of):		-								
8760,	certificate be executed riding physician and use as the burial-transit	ical		d												
9	rtifica ng ph	Med	IF FEMALE:	4					1		- Will-4-24	- 4				
Вох	ath ce tendi	an/l	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐Feta	ıldeath 3□	Ectopic pre						23d. Date Mor		ery Day	Year
0.	es that the death certifica igned by the attending pt be detached for use as t	Physician/Med	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregn 9□Unkno	ant at time of down	leath 5	Other (spe	ecify)		<u> </u>					,	
Δ.	that the sed by detac	Ph	Part II. Other significant conditi	ons contributing to de	ath but not res	ulting in the u	nderlying ca	iuse give	n in Part I.		23e. Did	tobacco	use contr	ibute to	the cause of	death?
Records,	law requires that the death as been signed by the atter 2 should be detached for u	d by	-			Ū	. •				1 🗆	Yes 2	No	3 🗆 Pro	bably 4	]Unknown
CO	w require been si should I	Completed		<u>-</u>							24a. Was	an	24b. V	Vere aut	opsy findings	available
Re	The lav ate has page 2	m o									auto perf	psy ormed? 2 No	- d	eath?	mpletion of 2 140	cause of
Vital		BeC	25. Was case referred to medica	.1					26. Place	of Death	(Check only					
f V	Physicien: this certificral director,	To	examiner? 1 Yes 2 No	Hospital: 1 🗆 l	npatient 2	ER/Outpatier	nt 3□ DO/	A Othe	r: 4 🖪 Nu	irsing Hor	me 5□Res	idence	6 □Othe	er (Speci	<i>fy)</i>	
n of	ding Phy h. After thi funeral	 	27. Mann of Death 1 Natural 5 □ Pendir	28a. Date of (Mont	of Injury h, Day Year)	28b. Time of Injury		Bc. Injury Work			28d. Describe	how inju	ry occurre	ed		
sio	Attending r death. sctor: After by the funer	cati	2 ☐ Accident investi	not be	of lainer. At la		M		/es 2 □		20f Lagation	(Ctroat a	and Alexander		n / Courte Alu	mhar
Division	or At after of Direction by	Certification:	4 Homicide determ	nined 286. Place	of Injury - At hing, etc. (Specif	ome, rarm, str (y)	eet, factory,	office		'	28f. Location ( City or To			er or mur	ai Aoute Nui	nber,
	Hospitel 14 hours a Funerel I tely filled		29a. Certifier 1 Certifyii	ng Physicien; To the	best of my kno	owledge, deat	n occurred a	at the tim	e, date an	d place, a	and due to the	cause(s	) and mai	nner as	stated.	
	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	Medical	(Check only 2 Medical one)	Exeminer: On the ba	isis of examination of stated.	ition and/or in	vestigation,	in my op	inion, dea	th occurr	ed at the time,	date an	d place, a	ınd due i	o the cause(	s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifie	or /			29c.	License	number			29d. Da	ite signed	(Month	Day, Year)	
•			<b>Y</b>		MD		I	> -3	13	12		09	5/19	3	102	
	4		30. Name and address of person					_	Cac~	- 1	344		2 10	7 5	7	
	,		JULIS PENOCH H		Toll SUP		714	9 1	LICEL	) E 16	ichn	~D	1	10		
	Sta Registi		31. Date filed (Month, Day, Year)		bgistrar's Signa	ature	n . 60									
					REPORT A	W A	District of the second									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 24a, 25 per doc 8845 7-21-05 vt. State of Maryland / Department of Health and Mental Hygiene For State Ragistrar Certificate of Death Reg. No. 🛴 Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Walter William Riley MAY 24TH, 2005 16:10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ALLEGANY MEMORIAL HOSPITAL CUMBERLAND If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 197M 2□ F Director 78 Oct.10,1926 Maryland 213-22-4273 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County irel", or items 23a or 28a-f show Exercit or most be notified at 1 ☐ Yes 2 ☐ No Director MD Garrett Accident 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1159 Devil's Half Acre Road 21520 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hyglene. Int: if item 27 is marked other than "naturel", or iter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) treumatic event, the Mudical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Callege (1-4or 5+) Salesman Retail 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bernard Dallas Riley Annie Mae Speicher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21520 1159 Devil's Half Acre Rd., Accident, MD John O. Riley/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Importent: if it any injury or o 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Addison Cemetery May 27,2005 Addison, PA <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 7 yane and Address of Facility Newman Funeral Homes, P.A. euma P.O. Box 275, Grantsville, MD 21536 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspirocha pnem on 9 - 064 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Oschuelin **Examiner** Small Sequentially list conditions, in any, leading to minisolate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events nding physician and resulting in death) Last Due to (or as a consequence of): JULKETT 25 Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Cher (specify) 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ erreinha 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 punpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2X No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ō within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0060478 MAY 25, 2005

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

CUMBERLAND, MD 21502

30. Name and address of person who ompleted cause of death (Item 23a) (Type, Print)

AHMAD, AFAQ, M.D., 625 KENT AVENUE, CUM

2005

32. Registrar's Signature

			State of Maryland / Department of Health and M	lental Hygie	ne	
		•	1 - State Registrar Certificate of Death	Reg.	No.2005	18732
П	Physicia	an	Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Philip O Robinson	May 28		4:40 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death Frederick Memorial Hospital  Frederick		4c. County of Deat Frederic	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye		hplace (State or Foreign untry)
ı	Director		148-09-4483 120 M 2 F 88 Yrs. Months Days Hours Min.	Oct 19.		w Jersey
	pud &		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits
	Maryli f sho	or	Maryland Frederick Monrovia			1 ☐ Yes 2 No
	r 28a-	rect	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Co	untry?
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examination instituted at once.	Funeral Director	3867 St Clair Court 21770		U.S.A.	
	er dea	nner	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	rs afte		1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No 1941 — If Yes, Give 1945 ☐ 1 ☐ Yes 2 ☑ No Specify:		Specify: W	Mite
9	2 hou atura ical E	Completed by	15 Decedent's Education 16a Decedent's Usual Occupation	161	b. Kind of Business/	Industry
215	ithin 7 ie. ieri "in	npie	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Custodian	ing	Board of	Education
7	led wild led	ပ်	12	e (First, Middle, Mai		
Maryland 21215-0036	d be filed ental Hygic ced other c event, I	o Be	Henry Elwood Robinson France		Klop	ne1
ary	shout nd Me r mark	ို	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run	al Route Number, C	ity or Town, State, Z	Zip Code)
	and 2 salth a n 27 is		Mrs. Violet Robinson/Wife 3867 St Clair Court, N			
ore	of He If iten		cemetery crematory or other place)		c. Location - City or	
Baltimore,	t. Pag rtmen rtant:		1			
Bal	permit. Pages Depertment of t important: If its any injury or o once.		21. Signature of Funeral Service Licenções  22. Name and Address of Facility Keeney & Basfore 106 Fast Church St	d P.A. Fu	neral Hom	e 1 01701
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	, Frederic or respiratory arrest	ck, Maryl	Approximate Interval Between
3	Pnysician		Immediate Cause (Final disease or condition a Respiratory failure			Onset and Death
	/Medical		resulting in death)  Due to (* as a consequence of):			
	Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate  b. Lunc Cancer  Due to (or pronsequence of):			months
V	ted nsit	nine	Sequentially list conditions if any, leading to immediate cause. Enter U identifying Cause (Disease or injury that initiated events  c.			
Ć.	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last  Due to (or as a consequence of):			
1760,	e X e	icai	d			
x 68	death certifica e attending ph d for use as th	Physician/Med	IF FEMALE:			
Вох	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?  in the past 12 months?  4 Pregnant at time of death 5 Other (specify)		23d. Date of deli Month	ivery Day Year
o.	0 0 D	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown			
٣.	res that igned b be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ord	w require been sig should b	ted t	Hypertension, leg ulcers	1 Tes	2 □ No 3 ₽ Pr	obably 4 Unknown
Records,	25 8	Completed by		24a. Was an autopsy	prior to o	topsy findings available completion of cause of
a H				performed 1 ☐ Yes 2 1		2 No
Vital		o Be	examiner?	h (Check only one) ome 5 ☐ Residenc	e 6 Other /Sper	ciful
of		n; To	27. Manger of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how		Sily)
Division	uttendin death. ctor: Aft the fur	ertification;	2 Accident investigation M 1 Yes 2 No			
ĬŽ		≝	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or Ru State)	ural Route Number,
	fter differ direct	핕				
	pital or Attendons after death	O	29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place.	and due to the caus	e(s) and manner as	stated.
	or A offer Dire	O	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the caus red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the Hospital or Attentivition 24 hours after deating the Funeral Director: completely filled in by the	Medical Certi	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.  29b. Signature and title of certifier  29c. License number	and due to the caus red at the time, date	se(s) and manner as and place, and due Date signed (Monti	stated. to the cause(s)  h, Day, Year)
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by i	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.  29b. Signature and title of certifier  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.  29c. License number	and due to the caus red at the time, date	Date signed (Month	stated. to the cause(s)  h, Day, Year)  2065
	To the Hospital or Att within 24 hours atter of To the Funeral Direct completely filled in by	edical C	29a. Certifier (check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, check only one)  1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.  29b. Signature and title of certifier  29c. License number  1062180  30. Name an address of pe son o completed cause of death (Item 23a) (Type, Print)  Fauzi Kizvi MP, 400 West 7th Street	and due to the causered at the time, date  29d.  M  2ef Fr	Date signed (Montile ay 28, ede n'C)	stated. to the cause(s)  h, Day, Year)  2065
	To the within 2 To the comple	Medical C	(Check only one)  2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.  29b. Signature and title of certifier  D 62180	and due to the caus red at the time, date 29d.  M  2ef Fr.	ee(s) and manner as and place, and due  Date signed (Month  ay 28,  ederic	stated. to the cause(s)  h, Day, Year)  2065

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Elsie E. Schrock 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner CUMBER Q If Under 1 Year | If Under 24 Hr Alle HEART DITA GANI Acred Birthplace State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days Hours Min. 1□M 2XF Months Director 9, 182-54-5866 81 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumetic event, the Madical Experiment sust be notified at 1 Yes 2 No Grantsville Maryland Garrett **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21536 245 Killdeer Lane TISA or Items 23e 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Be Completed by 3 Widowed 4 Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: If item 27 is marked other then ' Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ezra Yoder Amanda Yoder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Simon E. Schrock, Husband 245 Killdeer Lane, Grantsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Nurial 2 Cremation 3 Removal from State injury or Department of Importent: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Mountain View Cem, May 26, 2005 Salisbury, PA permit. 21. Signature of Funéral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. 179 Miller St, PO Box 275, Grantsville, MD 21536 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MetaStasic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any, localing to initial scause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto for as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Month Year in the past 12 months? Dav 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρe ICTION MAINUTRITION 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Anemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 No 1 ☐ Yes 2 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2/ No Certification: To this ierel Director: After th 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No uld not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospitel within 24 hours a To the Funerel I ing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier le of a 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number who completed cause of death (Item 23a) (Type, Print) 30. Name and address 9 DRIVE. DAN SueNo 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State MAY 2 4 2005 Registrar

		For State Registrar	State of Mai		artment of ertificate o		d Mental Hy	giene 20	105 1873	
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ter de	nu	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☐ Married</li></ul>	12. Was Decedent Ev Armed Forces?	79F IN U.S. 13	If Yes, specify C	Suban, Mexican, P	? (Specify Yes or No luerto Rican, etc.)	Blac	e - American Indian, ck, White, etc.	
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit of 94 Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 ahow any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sign dure on uneral Se, ice Lie	cense /		<ol><li>Name and Add</li></ol>	dress of Facility			, Maryland	-
permi Depa Impo any ir		Kandople	P. Noac		Moore H	uneral	Home, F	A.	ton MD 2162	^
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The state of late of l	/Ita	cien: artific	Φ					T	e of Death	(Check only on	10)		
1   Natural   2   Accident   3   Suicide   4   Homicide   5   Pending investigation   5   Pending investigation   6   Could not be determined   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   29a. Certifier (Check only one)   29a. Certifier (Check only one)   29b. Signature and dittle picertifier   29c. License number   29d. Date signed (Month, Day, Year)   32 Pegistrare Signature   31. Date filled (Month, Day, Year)   32 Pegistrare Signature	)	hysi his c	၉	1 ☐ Yes 2 No	1 □ Inp	_		4 L IN		-/-			(y)
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39 Name and address of person who completed cause of death (Item 23a) (Type, Print)  Robert Bonegan GBMC  State 31. Date filed (Month, Day, Year) 32 Jegistrans Signature		real of							, l				
39 Name and address of person who completed cause of death (Item 23a) (Type, Print)  Robert Bonegan GBMC  State 31. Date filed (Month, Day, Year) 32 Jegistrans Signature		Host 24 ho Fune Itely fi	lical	(Check only 2 Medical E	xaminer: On the basi	s of examination and	death occurred at for investigation, in	the time, date at my opinion, de	ath occurre	and due to the ca ed at the time, d	ause(s) and r ate and place	manner as s e, and due to	itated. o the cause(s)
39 Name and address of person who completed cause of death (Item 23a) (Type, Print)  Robert Bonegan GBMC  State 31. Date filed (Month, Day, Year) 32 Jegistrans Signature		o the ithin ; o the omple	Mec		and mailie	otatoo.	, 29c. L	icense number		2	9d. Date sign	ned (Month,	Day, Year)
39 Name and address of person who completed cause of death (Item 23e) (Type, Print)  RODETT DORGON GBMC  State 31. Date filed (Month, Day, Year) 32 Jegistrans Signature		F ≥ F 0		X LAN	20000	Orcalaci	of Do	00569	119		, -		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 7 per fh e844 6-2-05 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. ... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25, 2005 **Physician** 4:30 AM MARGARET ELIZABETH SHAW May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ALLEGANY CUMBERLAND LIONS MANOR NURSING HOME | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | AUG 23 193 5. Social Security Number 6. Sex 7. Age (68s. last birthday) Funeral 9. Birthplace (State or Foreign 1 □ M 2 K F Yrs. Director 218 34 4764 MARYLAND Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehow any injury or other traumatic event, the Medical Exat, ther must be notified at once. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1X Yes 2 No Director MARYLAND ALLEGANY FROSTBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? shaw, Maraaret 76 FROST VILLAGE 21532 U.S. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: 3 ₩ Widowed 4 Divorced WHITE Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 EXAMINER SHIRT FACTORY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GEORGE SCHELL VOURA LAWOR 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VOURA WHETSTONE / NIECE 19205 SHAFT ROAD, FROSTBURG, MD 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State LAUREL HILL CEMETERY 5/27/05 MOSCOW, MD ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Li 22. Name and Address of Facility 60 W. MAIN STREET SOWERS FUNERAL HOME, P.A. FROSTBURG, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat **Physician** METASTATIC CARCINOMA LUNG Adout one year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 →Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an s certificate has b lirector, page 2 s autopsy performed? 1 Yes 2**X** No Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Helm DI6901 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harlit Sidhu, MD 925 Bishop Walsh Rd. Cumberland, 31. Date filed (Month, Day, Year) 32. Paistrar's Signature State 2005 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 2005 Day **Physician** SHOWALTER 17/0PM 20 DNNA RUTH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 M F 204-03-2914 84 March 4, Penna. Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 7 is marked other then "naturel", or items 23a or 28e-f show treumatic event, the Medical Examinar must be publical at 1 ☐ Yes 2 No Director MD. Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14665 Byers Rd. 21742 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elmer Ryder Sadie Auman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hagerstown, Md. 21742 item 27 Clarence H. Showalter/Husband 14665 Byers Rd. other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite eny injury or ott 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Shank's Church Cemetery 5/25/05 Greencastle, Pa. 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility
Zimmerman And Son Funeral Home Inc.
45 S. Carlisle St. Greencastle, Pa. 17225 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonitis Physician aspiration disease or condition resulting in death) immediate /Medical Due to (or as a consequence of): **Examiner** Parkinsons Disease Vears Sequentially list conditions, a.y., icaching to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Due to (or as a consequence of): Completed by Physiclan/Medical IF FEMALE: esn nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? Heart Failure 24a. Was an Congestive autopsy performed? 1 ☐ Yes 2 ☐ No Renal Failure of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 ☐ Mo 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier centre Kuttrer-Sand no D47451 May 20, 2005 Kuttner-Sands up. Williamsport Williamsport Williamsport Williamsport 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Cynthia 32. Signature 31. Date filed (Month, Day, Year) State JUN 0 3 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 2005 **Physician** Month AUSTIN IMPSON ALVIN 6:15AM MA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ARBOGRIUR CARROLGION DRIVE PRODURI CIR If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Dec., 22,19 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 217-16-2860 Md. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or items 23a or 28a-f ahow traumatic event, the Medical Examiner must be notified at Frederick Md. Frederick 1 Yes 2 No Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? arrouten Drive 415 21701 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Z Yes 2 □ No M Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 1 No Specify Specity: Black 3 ☐ Widowed 4 ☐ Divorced 'natural', 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Automotive Auto Mechanic permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene important: If Item 27 is marked other that enty julyry or other traumatic event, Tha J enty. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen H. DISNEY Joseph H. TIMPSON ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timpson (wife) Mary E. 415 Comotton Dr. Frederick, Mayland 21701 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) May 23, 2005 Frederich, Md, Fairview Cem. 21. Signature of Funeral Service License 22. Name and Address of Facility Frency 41 Stome West Huy X. hedenc 21701 South 54. 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CON688 TiuE **Physician** HEAN7 WEEL /Medical Due to (or as a consequence of): **Examiner** ASC 921 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician; The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) the attending physician Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea:
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) P.O. I 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 Yes 2 No 1 Yes 2 🗗 No 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Certification; To 1 ☐ Yes 2 ☐ No 4 Nursing Home 5 Presidence 6 □Other (Specify) 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 105 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCAS ND / 15640705 Jum 7000 PILL NICH ME 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAY 2 0 2005 State Registrar

			1 - State of Marylan		artment of H		, ,			
			Decedent's Name (First, Middle, Last)				2. Date of Dea Month			3. Time of Death
	Physici /Medic		George Cooper Tower	s, S			May 26	, <sup>Day</sup> 005	Year 1	10:15 AM
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of E	Death	4c. County o		
	<b>-</b>		26846 Baker Road  5. Social Security Number 6. Sex 7. Age (In yrs.	ast hirthday)	Denton If Under 1 Year	If Under 24	Hrs. 8. Date of Birth		oline	Ce (State or Foreign
	Funeral Director		217-36-0669 15x 2□F 80	V	Months Days		Min. (Month, Day, April 25	,1925 I	Maryla	and
	and		Usual Residence of Decedent	, Town or Lo	cation				100	I. Inside City Limits
	Maryl f sho	ō		Dento						1 ☐ Yes 2 ☐XNo
	r 28a	irec	10e. Street and Number		10f. Zip Code		1	og Citizen of W United	hat Country	for of
	23a c	aiD	26846 Baker Road		21629			onrtea		merica
တ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Evantinal must be rollined at once.	Funeral Director	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 Yes, Give				? (Specify Yes or No- ruerto Rican, etc.)	Black	- American , White, etc	c.
21215-0036	hours a tural', c	by	3 Widowed 4 Divorced Year or Dates:			Specify:				asian
75	nin 72 In "nai	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give	lent's Usual Occupa kind of work done d DO NOT use retired)	uring most of	working	16b. Kind of Bus	siness/indus	stry
2	ad with	Com	7	1	Farmer			Far	ming	
Baltimore, Maryland	d be fill antal Hy ced oth	To Be	17. Father's Name (First, Middle, Last)  George Washington To	owers			Name (First, Middle, I nel Hanna			
ary	shoul and Me s marl	ř	19a. Informant's Name/Relationship ( <i>Type, Print</i> )		g Address (Street a		r Rural Route Number			ode)
e,	l and 2 lealth a im 27 I			-			Denton,			
nor	ages ant of H t: If ite		I Dunai 2 Dicientation 3 Dicentoval Itom State		sition (Name of natory or other place	- 1		20c. Location - C	•	
alti	mit. P partme portan r injur.		21. S'an ture of Juneral Service Ubersee	22	Cremato	s of Facility		Dover,		aware
<u>~</u>	permi Depa Impo any ir		1 Kandy More	- Mo	oore Fur 2 South	eral Secon	Home, P.	A. , Dent	on, N	MD 21629
	Pnysician		23a. Part1. Enter the disease, of complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Do not ente	er the mode of dying	, such as car	rdiac or respiratory arre	est,	lr.	pproximate nterval Between onset and Death
k	/Medical Examiner		resulting in death)  Lue to (or as a consequence)	ience of):	5000	10	×		10	200
		ner	Security list concluse if any, leading to immediate cause. Enter Underlying	erice of):	CLES	<u> </u>				200
	icate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that infitted events resulting in death) Last  C.  Due to (or as a consequence)	ience of).						
8760,	e be e) sician e buria	dicai E	d -	101100 01).						
9	tifficate ng phy as the	a)	V.							
Вох	eath certific attending p I for use as	ian/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopt 15	death 3 [	Ectopic pregnancy			23d. Date Mont	of delivery	ay Year
o.	that lhe de ed by the a detached f	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of do 9 ☐ Unknown	eath 5L	Other (specify)					-,
ds, P	eg Pe	by	Part II. Other significant conditions contributing to death but not rest	fling in the ur	derlying cause give	n in Part I.		pacco use contrib		cause of death?
Records,	w requir been si should	iete	Carps to Carps	Crock			24a. Was a	n 24b W	ere autops	y findings available
	sician: The law s certificate has b lirector, page 2 s	Completed					autops perform	y pri ned? de	or to comp ath? Yes 2	letion of cause of
/ita	cian: ertifica ector, p	Bec	25. Was case referred to medical examiner?				Death (Check only on			
of	Physic this c	. To		ER/Outpatien	3 DOA Other	4 LI NUISII	ng Home 5 1 eside			
o	Attending Physician: The I si death. rector: After this certificate haby the funeral director, page	ation	27. Mann Death  1	Injury	Work'	? es 2 □ No	204. 2000130 110	w many boodings	-	
Division of	or Atte	ertification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (St. City or Town	reet and Number n, State)	or Rural A	loute Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier  1 Certifying Physician: To the best of my knot (Check only 2 Medical Examiner: On the basis of examinal	wledge, death ion and/or inv	occurred at the time	e, date and pl inion, death o	lace, and due to the ca	ruse(s) and man	ner as state	ed. e cause(s)
	Fo the within 2 Fo the complex	Med	one) and manner stated.  29b. Signature and fittle of certifier		29c. License	number	29	9d. Date signed	(Month, Da	y, Year)
)	> = 0		Ahomo Cen V	W	()	59/	3 >	5/2	6/0	2 004
			30 Name and address of person who completed cause of death (Item	23a) (Type, I	Print)	10.	1	fo.	4. 0	1/10
		•	31. Date filed (Month, Day, Year)  32. Registrats Signal	ure (	DUY YUC	The same	Ch. JO	han 1	M) <	1651
	Sta Registr		MAY 2 7 2005 Agence	· K	Small 1					

_		ľ	For State Registrar	e of Maryland	-	artment of H		nd Menta	Hygie	- (1	05	18742
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date Mor	of Death	Day	Year	3. Time of Death
	/Medic		John Houster		, II			Ma	y 1	0 20	05	2:49 PM
	Examir	ner	4a. Facility Name (If not institution, give street an			4b. City, Town, or		Death		4c. County		
			Genesis HealthCare			Eas	ton	4 Um	15111	Т	albo	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	Yrs.	Months Days	Hours	Min. 8. Date	of Birth oth, Day, Yo 21,	9a <i>r</i> )	9. Birthp	lace (State or Foreign
	Director		222-22-4155 Usual Residence of Decedent	69				Nov.	21,	1935	Ma.	ryland
	land ow		10a. State 10b. County	10c. City, T	own or Lo	cation					1	0d. Inside City Limits
	Man, fired	to	Maryland Carolin	o Do	nton							1 ☐ Yes 2 ☐ No
	r 28e	Director	10e. Street and Number	e Dei	ILOII	10f. Zip Code				Citizen of W		
	72 hours after death with the Maryland naturel; or Itams 23a or 28a-f show deal Exambract must be modified at	al D	11404 Knife Box Ro	oad		21629	9		Ur	nited		tes of America
	deat	Funeral	11. Marital Status 12. Was	Decedent Ever in U.S. ad Forces?	13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Orig	in? (Specify Yes	or No-			an Indian,
9	or its	F	1 Never Married 2 Married 1 57	Yes 2 □ No s, Give			Specify:	· dono i nodin, c	10.7			
93	urei',	d by	3 ☐ Widowed 4 ☐ Divorced Year	or Dates:						Specify	Cau	casian
215-0036	"nat	Completed	15. Decedent's Education (Specify only highest grade comple	eted)	(Give	lent's Usual Occupa kind of work done of DO NOT use retired	durina most i	of working	16	b. Kind of Bu	siness/In	dustry
7	withir ane. than	du		ege (1-4or 5+)			,	iaian		Aviat	ion	
2	filed Hygie ther		12 17. Father's Name (First, Middle, Last)		AV	ionics T		's Name (First,				
Thawley e. Maryland	2 should be filed within and Mental Hygiene. Is marked other than "eumatic event, It a Me.	o Be	John Houster	n Thawley	. Jr			ace Ma				v
M Z	shoul nd Me mark mati	To	19a, Informant's Name/Relationship (Type, Prin			g Address (Street a						
ha	nd 2 st Ith ar 27 is r treu		Ellen K. Thawley									land 2162
الم الم	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatlth and Mental Hygiene. Important: if item 27 is marked other than "naturel; or itams 23a or 28e-f show eny injury or other treumatic event, the Maralcal Examinating the indiffed at once.	1	20a. Method of Disposition	20b. Plac	e of Dispo	sition (Name of natory or other place	1	Date	200	c. Location -	City or To	wn, State
John T	Pages ent of nt: If it ry or o		1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal 3 4 ☐ Donation 5 ☐ Other (Specify)	from State		Cremate		:/11/20	OF D	20110	Des	1
	permit. Pag Department Important: I eny Injury o											
ä	permi Depa impo eny ir once.		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	1 som	- M	oore Fu	neral	Home,	P.A	Dont		MD 21620
			23a. Part1. Enter the disease, or complications	that caused the death.	Do not ent	er the mode of dying	g, such as c	ardiac or respira	tory arrest	Dent	OH,	MD 21629 Approximate Interval Between
	Pnysician			Colonic	100	chroma	- mat	astation	10/1	ver		Onset and Death
	/Medical		disease or condition resulting in death)	ue to (or as a consequer		2010100	11101				_	J
	Examiner		Conventially list and disings									
	n .≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enfer Underlying Cause (Disease or injury that initiated events c.	ue to (or as a consequen	ice of):							
	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last									
0.0	e exection a	Ë	Di	ie to (or as a consequen	ice of):							
68760.	icate b physic s the b	dical	d									
9	teath certifica attending pl	Med	IF FEMALE:									
Вох	ath c attend for us	Physician/M	in the past 12 months?	s, outcome of pregnancy Live birth 2  Fetal de	ath 3	Ectopic pregnancy				23d. Date Mor		Day Year
0.0	at the de by the a	yslc		Pregnant at time of deat Unknown	n 5∟	Other (specify)			<u>.                                    </u>			
	res that tigned by		Part II. Other significant conditions contributing	to death but not resulting	ng in the u	nderlying cause give	en in Part I.	236	. Did tobac	co use contr	ibute to th	e cause of death?
d S	sign sign d be	d by			•	, ,			1 🗆 Yes	2 🗆 No	3 🗌 Prob	ably 4 Unknown
Ö	w require been si should I	Completed						240	. Was an	24h W	loro auto	psy findings available
ge.	has be 2	mp				<u> </u>		_   2-0	autopsy performed	p	rior to cor eath?	npletion of cause of
0	ician: The l certificate ha rector, page	ပိ	25. Was case referred to medical						Yes 2	No 1	☐ Yes	2 No
<u> </u>	sician: certifica irector,	o Be	examiner?	1 ☐ Inpatient 2 ☐ ER	Outpation	t 3 DOA Othe		of Death (Check sing Home 5		o	v (Canaih	41
o		$\vdash$			Bb. Time of		/at			injury occurre		//
on	ding P th. : After I	tlor	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		<br Yes 2□N	0				
Division of Vital Becords.	ol or Attendi after death. I Director: A d in by the fu	fica	3 Suicide 6 Could not be 28e.	Place of Injury - At home	e, farm, str	eet, factory, office		28f. Loc	ation (Stree	t and Numbe	er or Rura	I Route Number,
Ö	el or A s after il Direction	Certification:	4  Homicide determined	building, etc. (Specify)				City	or Town, S	itate)		
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier Check only 2 Medical Examiner: On	o the best of my knowle	dge, death	occurred at the tim	ne, date and	place, and due	to the caus	e(s) and mai	ner as st	ated.
	in 24 in 24 the Fi	Medical	one) and	manner stated.	Tandor In	restigation, in my op	oinion, deatr	1 occurred at the				
	To T	Σ	29b. Signature and title of certifier	37		29c. License	number	فسرفسف	29d.	Date signed		
			11119	·		2	1251	7 2/		5.1	0.0	25
			30. Name and address of person who completed	cause of death (Item 23			0.1	F- ~-		WV	910	01
			1. LICHUET CHONTEN	11) 610 [		IMANS 1	VITNE	1115	ION I	.117	216	01
	Sta Regísti	-	31. Date filed (Mortil), Day, Year) 2005	32. Registrar's Signature		Carel B						
	riegisti	-CII		A AMORAGE RA	- 69							

Arline Tydings 05-03365 RPD

?D	3303		1 - For State Registrar		aryland / D	epartmer Certificat					Reg. No.	2005	18743
	Physici	an	Decedent's Name (First, Middle, La.	•					2	. Date of De. Month	ath Day	Year	3. Time of Death
	/Medic		Arline Elizabeth							May 15	-		0356 A M
7	Examir	ner	4a. Facility Name (If not institution, give		)			Location of	of Death		4c. C	ounty of Death	
		v	Good Samaritan Ho 5. Social Security Number 6. S		na //m /n at hinth	Balt:	LMOre	If Under	24 Hrs o	Date of Bird		0.514	
	Funeral Director			M 202KF 7. A	ge (In yrs. last birth 68 <sup>Yı</sup>	Months	Days	Hours	Min.	. Date of Birt (Month, Da	y, Year)		lace (State or Foreign try)
			Usual Residence of Decedent		00				D6	ept. 2	8, 19	36 Mar	yland
	yland		10a. State 10b. County		10c. City, Town	or Location						1	0d. Inside City Limits
	B Mai	ctor	Maryland Anne Ar	und <b>e</b> 1	Annapol	is							1 ☐ Yes 2 🙀 No
	or 28	Oire	10e. Street and Number			10f. Zip	Code				10g. Citize	on of What Cour	itry?
	ath w	Funeral Director	622 Ridgely Avenu	e			401					ed Stat	es
	er dez	une	11. Marital Status	12. Was Decedent Armed Forces	}	13. Was Dece If Yes, spe	dent of Hi cify Cuba	ispanic Ori n, Mexicar	igin? (Specif n, Puerto Ric	fy Yes or No can, etc.)	- 14	Race - Americ Black, White,	
36	s afte	by F	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:	No	1 🗆 Yes	2 <b>∳</b> No	Specify:			s	pecify: whi	te
21215-0036	72 hours after death with the Maryland natural', or items 23a or 28a-f show dissi Examinat must be rodified at	ed b	15. Decedent's Ed		16a F	ecedent's Usu	al Occurs	ation				of Business/Inc	
15	nin 72 n na n na	Completed	(Specify only highest gra	de completed)		Give kind of wo life. DO NOT u	rk done d se retired	during mos	at of working		705. 14119		20011)
212	yene.	mo	Elementary/Secondary (0-12)	College (1-4or 2		lerk					Nav	al Acad	emv.
Þ	e filed til Hygie othar vant, til	BeC	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name (F	First, Middle,			<u> </u>
/al	should b nd Menta r markad umatic a	10	Henry Vernon Tyd	ings				Chr	istine	e Nelse	on		
Maryland	nd 2 sho lith and 27 Is mu		19a. Informant's Name/Relationship ( Nelson Tydings/			Mailing Address B <b>eech</b> wo						Town, State, Zip	Code)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked othar than "natural", or items 23a or 28a-f show any injury or other traumatic avant. The Medical Evantinational be notified at ance.		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □		20b. Place of E cemetery,	isposition (Nar crematory or c	ne of other place	e)	Date	0	20c. Loca	ation - City or To	
Ē	it. Partimer rtant njury		* 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Euneral Service Licer		Baltimo				5-19-0			timore,	
Ba	permit. Page Department of Important: If any injury or		23a. Part 1. Enter the disease, or com	matth	1	147 Du	ike o	f Glo	oucest	er St	. Ann	apolis,	1 Home, Inc MD 21401
8760,	rate be executed /Medical Examiner upsician and the parial-transit the parial-transit in	dical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Einter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):								Onset and Death		
.O. Box 68	ath certific	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ★Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death	3 Ectopic pi					23	d. Date of delive Month	ry Day Year
<u>α</u>	uires that the de signed by the a Id be detached f		Part II. Other significant conditions of	ontributing to death t	out not resulting in t	he undertving o	ause give	en in Part I.		23e. Did to	obacco use	contribute to th	e cause of death?
rds,	w requires been signi should be	ed by	a	monary	and all	ctive	De	Sece	se	101	fes 2□	No 3∏Prob	ably 4 Dunknown
Vital Records,		Completed by								24a. Was autop perfor 1 ☐ Yes	an sy rmed? 2000	death?	osy findings available inpletion of cause of 2 No
/ita	Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Haaritali			-		of Death (C	Check only o	ne)		
of		은	1 XYes 2 No	Hospital: 1 Inpati				4 140				Other (Specify	)
U C	ing After	lon	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Tir uy Year) Inji	ne of 2	8c. Injury Work	rat ⊲? Yes 2 []i		d. Describe h	now injury o	occurred	
Division	l or Attending after death. Diractor: After i in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In	jury - At home, fam			163 2	-			Vumber or Rura	l Route Number,
ā	ospital or hours atte unaral Dir ly filled in	Cert			ic. (Specify)	d==4h				City or Tow			
	H 24	edical	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☑ Medical Exan one)	ysician: To the best liner: On the basis of and manner st	of examination and/	or investigation	at the tim , in my op —	ie, date an pinion, dea	id place, and ith occurred	at the time,	date and pl	lace, and due to	the cause(s)
	To the To the Comple	Σ	29b. Signature and title of certifier	Al I One in	ind	290	OCMI					signed <i>(Month, l</i> 5, 2005	Day, Year)
			30. Name and address of person who	completed cause of	death (Item 23a) (T	ype, Print) - 111 Pe	enn S	Stree	t Bal	Ltimor	e. Ma	ryland	21201
	Sta Registr		31. Date filed (Month, Pay Year) MAY 1 8	2005 32. R risti	rar's Signature	Soul	رع				, 110		<b></b>
				,	-151	-							

			1 - For State Registrer	State of I	Marylan		artment of I				ne . <sub>No.</sub> 2	005	18766
	O. Dhuaisi		1. Decedent's Name (First, Middle	e, Last)				-	1 1	Date of Death Month	Dav	Year	3. Time of Death
	Physici /Medic				ghn				M	ay 2	23,	2005	5:50 P M
	Examin	er	4a. Facility Name (If not institution	•		1	4b. City, Town,		n of Death			nty of Death	•
4	<b>.</b>		Shady Grove 5. Social Security Number		HOSPIC Age (In yrs. 1		Rockvil		er 24 Hrs. 8 C	Date of Birth		gomery 9. Birtho	lace (State or Foreign
3.0	Funeral Director		438-56-8600	1 <b>X</b> M 2□ F	66	Yrs.	Months Days	Hours	Min. 07	Month, Day, Ye /19/193	88	Louis	ntry)
	pu ,		Usual Residence of Decedent										
	faryla shov	ō	10a. State 10b. County	-		, Town or Lo	cation					1"	0d. Inside City Limits 1 ☐ Yes 2√ No
	the N 28a-f	Director	VA Fair:	tax	Lor	ton	10f. Zip Code			100	Citizen	of What Coun	
	3e or		7617 DeVries D	r.			22079	9			J.S.A		
	death	Funeral	11. Marital Status	12. Was Decede	nt Ever in U.	S. 13.	Was Decedent of		origin? (Specify	Yes or No-		Race - Americ	
9	after or Ite		1 Never Married 2 Marr	ied 1 X Yes 2	□ N/o		1 ⊡Yes 2 ဩTNo			Π, Θιο.)		Black, White, cify: Bla	
003	n 72 hours after death with the Maryland "natural", or Items 23e or 28a-f show offer Example of the modified at	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	1958 <del>-</del> 1978					1.40			
15	- 29	olete	15. Deceden (Specify only highes	st grade completed)		(Give	dent's Usual Occu kind of work done DO NOT use retire	during mo	ost of working	168	b. Kina of	f Business/Ind	austry
212	d within giene. ir than "	Completed	Elementary/Secondary (0-12)	College (1-4-	or 5+)	Comp	iter Prog	gramm	er		U.S.	Gover	nment
pu	be filed that Hygie od other is event.	Bec	17. Father's Name (First, Middle,	Last)				18. Moth	her's Name (Fir.	st, Middle, Mai	den Sum	name)	
yla		2	Joseph Vaughn						nes Wil				
Baltimore, Maryland 21215-0036			19a. Informant's Name/Relations	hip <i>(Type, Print)</i>			ng Address (Stree				•	wn, State, Zip	Code)
e,	is 1 and 2 of Health a item 27 is other trai		Annette Vaughn 20a. Method of Disposition		20b. P		DeVries sition (Name of matory or other pla		Date	-		n - City or To	wn, State
πOI			1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		II e		natory or other pla o Nationa	ł.	06/01/2	005 Tr	-i ano	ıle. Vi	irginia
altin	コモモラ		21. Signature of Funeral Service		ı Qu	Control of the Contro	2. Name and Addr						
ä	Department of the population o		1 Kabert	Mc Call			13318 Oc	coqua	n Road,	Woodbr	idge	, Virg	ginia 22191
ı			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau only one cause on eac	sed the death n line.	. Do not ent	er the mode of dy	ing, such a	is cardiac or res	piratory arrest,			Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	_ a	NEU	MON	JIA					9	Onset and Death
	/Medical Examiner		Due to (or as a consequence of):										
	A 17.5	er	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	b. Due to (or	as a consequ	ence of):							L. On The
1	be executed sician and burial-transit	Examine	Cause (Disease or injury that initiated events	<b>S</b>									
ó	a exec an an rial-tr	Еха	resulting in death) Last	Due to (or	as a consequ	ence of):							
8760,	ate hy:	dlcal		d									
9	leath certific attending p	Ψ.	IF FEMALE:	23c. If yes, outco	me of oregna	ncv						D 4 4 1 E	
Вох	atten for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 ☐ Fetal t at time of de	death 3	Ectopic pregnance Other (specify)	;y				Date of delive Month	nry Day Year
0	that the ded by the detached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow			5 - mor (openny) _						
s, p	es that igned b	by Pi	Part II. Other significant condition	ons contributing to deat	h but not resu	lting in the u	nderlying cause gi	ven in Part	t I.	23e. Did tobac	co use co	ontribute to th	ne cause of death?
ord	w require been sig should b									1 🗌 Yes	2.⊉No	3 ☐ Proba	ably 4 □Unknown
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of Vital Record	Th ate pag	Соп								performed 1 ☐ Yes 2.2		death? 1 ☐ Yes	2.12 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Ot	hon	ce of Death (Ch				
of		- To	1 Yes 2 No 27. Manner of Death	28a. Date of		ER/Outpatier 28b. Time of	IL 3 DOA	4 🗆 1	Nursing Home 28d.	5 Residence Describe how			")
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Vis	il or Attendii after death. Director: A d in by the fu	ifica	3 Suicide 6 Could	inned 286, Place of	Injury - At ho etc. (Specify	me, farm, str	eet, factory, office			ocation (Stree		mber or Rurai	I Route Number,
	tel or rs afte al Dir	Cert	Tiomode	- Juliukig	oto. (opacity		·						
	To the Hospitel or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical	ig Ph <b>ysician:</b> To the be <b>Exeminer</b> : On the basi	s of examinat	wiedge, deatl ion and/or in	n occurred at the t vestigation, in my	ime, date a opinion, de	and place, and c eath occurred at	due to the caus the time, date	e(s) and and plac	manner as sta e, and due to	ated. the cause(s)
	To the within 2 To the complet	Med	one)  29b. Signature,and title of certifie	and manner	stated.		29c. Licen	se number		29d.	Date sig	ned (Month, L	Day, Year)
	F 3 F 8		Mul	Ague	P. KUI	2/3/1/12	Auro	D	46187	2 MA	4 6	23 2	2005
	1		30. Name and address of person	who completed cause	1		Print)				, ,		
_	5		ATIT P. KURU	vice A, MC	) - (11	25 x	POCKVILL	EP	IKE #2	as Ro	CKUC	LLE,	MD 20852
	" Sta		31. Date filed (Month, Day, Year)	0.00	strar's Signa		MA			,			
	Registr		JUN 0 3	2003	100 10								
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			1 - For State Ragistrar		Marylan		artment of H				Reg. No.	05	1874	5
Н	Physici	an	Decedent's Name (First, Middle	e, Last)						Date of De. Month	ath Day	Year	3. Time of De	
	/Medic		PRESTON	WIS						AY		005	12:48	М
	Examin	er	4a. Facility Name (If not institution	n, give street and numb	er)		4b. City, Town, or	Location of	of Death		4c. Cour	ty of Death		
			10922 WES 5. Social Security Number		OAD Age (In yrs. I	last hirthday)	BISHOP\ If Under 1 Year	/ILLE	24 Hrs.   g	Date of Birt		CESTE	R place (State or Fo	oroian
	Funeral Director		222-22-3262	1 <b>X</b> M 2□F	67	Yrs.	Months Days	Hours	Min.	(Month, Da	v. Year)	Cou	AWARE	) i eigi i
			Usual Residence of Decedent								.,,,,			
	arylar		10a. State 10b. County		10c. City	y, Town or Lo	cation					•	10d. Inside City L	
	88-1 1	Director		CESTER		BISHOP				-1			1 🗆 Yes 2	Ž NO
	72 hours after death with the Maryland Insturel', or iteme 23e or 28e-f ehow disal Exac, itemmet be molified at	Dire	10e. Street and Number 10922 WEST I	INE ROAD			10f. Zip Code <b>21813</b>				10g. Citizen o	f What Cou ED STA	•	
	ne 23	Funeral	11. Marital Status	12. Was Decede		S. 13.	Was Decedent of H	ispanic Ori	gin? (Specify	Yes or No		ace - Ameri	can Indian,	
9	or ite		1 Never Married 2 Mar			i	f Yes, sp <i>eci</i> fy Cuba 1 □ Yes 2 <b>X</b> No			an, etc.)		ack, White,		
21215-0036	rai', c	d b	3 ☐ Widowed 4 M Divorced	If Yes, Give Year or Date	es:		1 L Yes 2E3 No	Specify:			Spec	ify: BL	ACK	
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121	within ene. than "	m m	Elementary/Secondary (0-12)	College (1-4	or 5+)		OO NOT use retired SONRY WOR	•			CON	STRUC'	TT (N	
2	D		8 17. Father's Name (First, Middle,	Last)		11411	JOHNEL WOR		er's Name (Fi	rst. Middle.	Maiden Sum		TION	
Maryland	be do do	To Be	EUGENE WI						RGARET		LEY			
Mar	12 sh h and 7 ie m traum		19a. Informant's Name/Relations <b>ELTON JAMES</b>	-	rep )	0	ng Address (Street of DEVON D						Code)	
	s 1 and 2 f Health item 27 other tra		20a, Method of Disposition	MISE (DECIL	20b. P	lace of Dispo	sition (Name of	1	Date		20c. Location		own, State	_
altimore,			1 XBurial 2 Cremation 4 Donation 5 Other (5		te CAI	LVARY I	PENTECOST	ÅL	MAY 25	,2005			LLE, MD	
薑		1	21. Signature of Funeral Service		СНС		EMETERY  2. Name and Addres							
ñ	permit. Departr Importu any inji		Robert St	for the	3		ATSON FUN							
			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that cau	sed the death	n. Do not ent	LLLSBORO . er the mode of dyin	g, such as	cardiac or re	spiratory ar	rrest,		Approximate Interval Betwee	en .
. III	Physician		Immediate Cause (Final disease or condition	MIT	tatai	// 04 69	Can	1000					Onset and Dea	th
	/Medical		resulting in death)	Due to (or	as a consequ	uence of):	1	Cerv					1 Mari	Υ
п	Examiner		Sequentially list conditions	b										
	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	uence of):								
	and -trans	cam	that initiated events resulting in death) Last	C. Dun to (or	as a consequ	unnen of\-								
8760,	be executed siclan and burial-transit			Due to (or	as a consequ	derice or).								
387	phys the	dic		d										
9 x	death certificate be executed e attending physician and od for use as the burial-transii	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna	incy					23d L	ate of delive	erv	
Вох	death atter	clar	in the past 12 months?		n 2∏Fetal it at time of de		Ectopic pregnancy Other (specify)	·			1	Month	Day Year	r
0	that the de led by the a detached b	hysi	9 Unknown	9□ Unknow	n								Matthews of the Committee of the Committ	
ď.	The law requires that the te has been signed by thoage 2 should be detache	ру Р	Part II. Other significant conditi	ons contributing to dea	th but not rest	ulting in the u	nderlying cause give	en in Part I.		23e. Did to	obacco use co	ntribute to t	he cause of deat	h?
rds	w require been sig should b									1 🗆 ነ	Yes 2□No	3 Prot	ably 4 Unkr	nown
Vital Records,	aw requas been 2 should	Completed								24a. Was		. Were auto	psy findings avai	ilable
Ě	The la	mo.								perfo	rmed? 2 No	death?	2 No	
ita/	iclen: Th certificate rector, pag	Be (	25. Was case referred to medica examiner?					26. Place	of Death (C	heck only o	me)			
of V	Physicien: this certific ral director,	ဥ	1 Yes 2 No			ER/Outpatier		4 🗆 Nu	ırsing Home		dence 6 🗆 O		(y)	
n c		on:	27. Manner of Death  1 Natural 5 Pendir	ig	Day Year)	28b. Time of Injury	Wor			Describe I	how injury occ	urred		
Sic	tten deati tor: the	icat	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	not be Oss Blood of	Injuny - At ho	me form et	M 1 D	Yes 2 🔲		Location /	Street and Nur	nhar or Dur	al Route Number,	
Division	l or Att after d Direct I in by t	Certification:	4 Homicide determ	nined 289. Flace of building	, etc. (Specif)	/)	eet, ractory, office		201.	City or Tov		IDE OF AUTO	ai noute ivamber,	
land.	spitel ours nerei filled		29a, Certifier 1 Cartifying	ng Physician: To the b	est of my kno	wledge, deat	occurred at the tin	ne. date an	d place, and	due to the	cause(s) and r	manner as s	tated.	
	To the Hospitel or Ai within 24 hours after of To the Funerel Direct completely filled in by	edical		Examinar: On the bas and manne	s of examina									
	To the within 2 To the complet	Me	29b. Signature and title of certifie	er A 34 /34 :			29c. Licens				29d. Date sign			
)			I whant	2. Chitan	MO	)	000	56	770	0	5/2	010	5-	
1			30. Name and address of person	who completed cause	of death (Item	23а) (Туре,	Print)				1	1		
H	, 4		KOBERT L	. CLINTO	DN, 1	10 1	000 45 E.	CAR	ROLL	. 57	SAL	SBUK	my m	
	Sta		31. Date filed (Month, Day, Year)	2005	istrar's Signa	ture							2180	1
	Registi	वा		LUG JAM	early 1	U A	The same of the sa							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 1053 **Physician** Woodward May 6, E1mer S. 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Caroline Denton Caroline Nursing Home If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Nov.14,1922

8. Birthplace (State of Country)
Maryland Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1**√**2M/ 2□ F 82 215-16-3775 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Exactings must be notified at Federalsburg 1 ☐ Yes 2 → No MD Dorchester Be Completed by Funeral Director 10f. Zip Code 21632 10g. Citizen of What Country? 10e. Street and Number ō 4813 Preston Road United States Нета 23а filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: ¶43-45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Marned White ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 3 ★Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Masonry Brick Mason permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Important: If item 27 is marked other 11 any injury or other traumatic event, IIIs once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Hattie Shufelt Mayo Stewart Woodward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6814 Hunting Creek Rd., Hurlock, MD 21643 Charles S. Woodward/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Hurlock, Maryland Fastern Shore Veterans Cem. 05/12/05 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, P.A. Michael F. Eskow 216 N. Main St., Federalsburg, MD 21632 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hoovic distructive **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical Examiner THEDICAL EXAMINER ng physician and as the burial-transit that the death certificate be executed ON APPROVED B Due to (or as a consequence of): P.O. Box 68760. CERTIFICA esn IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by The law requires 1€Yes 2□No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? (multi-infarct) 24a. Was an autopsy page performed 1 Yes 2 No 2 No this certificate 1 Yes or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending April 14,2005 6:15pm 1 Yes 2 100 Subject fell within 24 hours after deave.
To the Funaral Diractor: A death. 2 Accident investigation 6 Could not be determined Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Nursing & Rehabilitation Center 28f. Location (Street and Number or Rural Route Number, Caroline Nursing & Rehab 520 Kerr Ave. Denton, Mi 4 - Homicide Hospital 🔝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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			i lease				Health and M	•	•	
			1 - For State Registrar	0.0.0		rtificate o			Z U U 5	18747
			Decedent's Name (First, Middle, Last	)				2. Date of Death		3. Time of Death
	Physici /Medio		MARY ANN WHALEN					5/14/200	Day Year	2:33 A <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give				n, or Location of Death		4c. County of Death	1
			1514 MARLBOROUGH			CROFTO			ANNE ARUNI	
	Funeral Director		5. Social Security Number 6. Se 130–18–9616	x 7.Age □M 2∏TF	(In yrs. last birthday) 78 Yrs.	If Under 1 Ye Months Day		8. Date of Birth (Month, Day, Y 3/2/1927	(ear) 9. Birth Cou	place (State or Foreign intry)
			Usual Residence of Decedent		70			3/2/172/	NEW	ÝÓRK
	nylan thow	_	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Ba-1 s	cto	MARYLAND ANNE ARUN	IDEL	CROFTON					Yos 2 No
	with th	Director	10e. Street and Number			10f. Zip Code	В		g. Citizen of What Cou	intry?
	s 23	Funerai	1514 MARLBOROUGH C	OURT 12. Was Decedent 8	variall S 12.1	21114	4 Historia Osisina /Ca	US		
10	fter d	F	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces?	0	f Yes, specify C	of Hispanic Origin? (Speuban, Mexican, Puerto	Rican, etc.)	14. Race - Amer Black, White	
936	al', o	by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 257 N If Yes, Give ↑ Year or Dates:		1□Yes 2X11	No Specify:		Specify: WH	LTE
Maryland 21215-0036	be filed within 72 hours after death with the Maryland hal Hygiene. dother than "natural", or Items 23e or 28e-1 show event, the Medical Evaridaet must be notified at	Completed	15. Decedent's Edu (Specify only highest grad		16a. Deced	dent's Usual Occ	cupation ne during most of work. ired)	ina 16	b. Kind of Business/I	ndustry
121	within ne.	mpi	Elementary/Secondary (0-12)	College (1-4or 5	+)			1	TD MD ANGD	DEL EL CAL
d 2	filed Hygie Hygie other I		12 17. Father's Name (First, Middle, Last)		ADMIN	ISIKAII	VE ASSISTAL	N I A  e (First, Middle, Ma	IR TRANSPO	DRIATION
lan	id be ental ked o	To Be	JOSEPH CHARLES RAE	EDY				ARSHALL	,	
ary	2 should be and Mental is marked o	-	19a. Informant's Name/Relationship (7)		19b. Mailir	ng Address (Stre	et and Number or Rura	al Route Number, C	City or Town, State, Zi	p Code)
	₽ ≦ Z =		JANE HORST / DAUG	GHTER			COURT MAR	TINSBURG,	WV 25401	
Baltimore,	0 0		20a. Method of Disposition  1 XBurial 2 Cremation 3 F	Removal from State	20b. Place of Dispo	sition <i>(Name of</i> natory or other p MONT	place)	Date 20	c. Location - City or T	own, State
ţ	tment tent:		' 4 ☐ Donation 5 ☐ Other (Specify)		MEMORIAL	GARDENS	5/17		VIDSONVILI	
Bal	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licens	600			dress of Facility ROB			AL HOME
			23a. Part1. Enter the disease, or complishock, or heart failure. List only o	lications that caused			NAPOLIS ROA			Approximate
B	Discontinuo.		Immediate Cause (Final	ne cause on each lin	e.	JA 1	Lower		'	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a	consequence of):			-		21 mor
	Examiner		Sequentially list conditions	b						
	pe iii	iner	Sequentially list conditions, if my last of cause. Enter Underlying Cause (Disease or injury that initiated events		consequence of					
	and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
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687	¥ 5 0			0.						
Вох	death certificat e attending phy of for use as th	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		Ectopic pregna			23d. Date of deliv	егу
	0 00	Physician/Med	in the past 12 months?	4 □ Pregnant at 1		Other (specify)			Month	Day Year
P.0	that the de led by the a detached f	Phy	9 Unknown							
Ś	9 P 9	by	Part II. Other significant conditions co	ntributing to death bu	it not resulting in the ur	iderlying cause	given in Part I.		cco use contribute to t No 3 □ Pro	he cause of death?
0.00	w requir been s should	etec		•						
Records,	hasl hasl ge 2 s	Completed						24a. Was an autopsy performed	prior to co	opsy findings available empletion of cause of
		e Co	25. Was case referred to medical					1  Yes 2 €		2□ No
5	Physicien: this certific ral director,	0 8	evaminer?	Hospital:	nt 2 ☐ ER/Outpatien	t 3 DOA	Other: 4 Nursing Hor	n (Check only one)	e 6 Other (Special	6.1
		n: T	27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time of	28c. In		28d. Describe how		<i>y</i> /
ioi	Attending r death. sctor: After y the fune	atic	1 Accident 5 Pending investigation	(	,,,		☐ Yes 2 ☐ No			
Division	I or Attenation after death Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc.	ry - At home, farm, stre . (Specify)	eet, factory, offic	:e :	28f. Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,
	pitel	i Ce	29a. Certifier Certifying Phy	nining. To the heat o	f my knowledge, death		time, date and place, a		()	
	To the Hospitel or Attenwithin 24 hours after deal To the Funerel Director: completely filled in by the	ledicai	(Check only 2 Medical Exami	ner: On the basis of and manner stat	examination and/or inv	estigation, in my	y opinion, death occurre	ed at the time, date	and place, and due to	tated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Lice	nse number	29d.	Date signed (Month,	Day, Year)
•			1.204	rellen	~	12	38/18	1	MAY 16	,2005
			30. Name and address of person who co	ompleted cause of de	ath (Item 23a) (Type, I	Print)	TEATE SE	2 12 1/-	· \m 7	14111
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra		0765	CANEDE	YUZUN	18/0 6	, , - ,
	Registr		MAY 18	2005	on it	from the				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month GLORIA MARIE WATTS /Medical 2005 May 19 9:15am 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Civista Medical Center Charles La Plata If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 ☐ M 2 🖾 F Director Yrs. 42 578-88-0013 SEPT.23,1962 MARYLAND Usual Residence of Decedent 10b. Count 10a. State 10c. City, Town or Location 7 is markad other than "natural", or Items 23a or 28a-f show traumatic avant, the Medical Examinat must be redified at 10d. Inside City Limits Director XYes 2 No MARYLAND CHARLES PLATA LΑ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 6165 BIVINS PLACE 14. Race - American Indian, Black, White, etc. 20646 12. Was Decedent Ever in U.S.
Ammed Forces?

Xi Xi Yes 2 □ No
If Yes, Give 1989-1993 1□ Yes 2 ☑ No
Year or Dates! 989-1993 1□ Yes Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours after and Mental Hygiene. Never Married 2☐ Married Specify: 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 COOK JOHNNY BOY RIBS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN CHILDS BROWN IDA LUCILLE WATTS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any injury or othar traum <u>once.</u> 6165 BIVINS PLACE, IDA L. WATTS- MOTHER LA PLATA, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SACRED HEART CEM. ! 5-27-05 LA PLATA, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, A PLATA, MARYLAND 20646 LA PLATA, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Intracranial **Physician** Bleed /Medical Due to (or as a consequence of): Examiner HTT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine hysician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death Check on one examiner? Hospital: 1 Inpatient 2 X EN/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 XNo 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide filled in within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D-0057999

Registrar
DHMH 17 Rev 1/2001

State

n

Box 68760.

P.0.

of Vital Records,

Division

MANISHA J. JARIWALA MD 11345 PEMBROOKE SQUARE WALDORF MARYLAND 20603

30. Name and address of page on who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JUN 0 3 2005

			Please i		aryland / De			-	giene o	
		•	1 - For State Registrar	State of Mic	-	ertificate of			Reg. No.	18749
			Decedent's Name (First, Middle, Last)					2. Date of De	nath _	3. Time of Death
	Physici /Medio		Warren Le	ee Yates	5			May	19 2005	11:38 PM
	Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,	or Location of Deat	h	4c. County of Dea	th
			14960 Greensbo			Golds		0 Date of Bir	Caroli	
	Funeral Director		212-42-3744	M 2□F	e (In yrs. last birthda 61 Yrs.	Months Days		8. Date of Bir (Month, Da Feb. 27	1944 Mai	thplace (State or Foreign ountry) Cyland
	fand ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mary a-f sh	to	Maryland Carol	ine	Golds	boro				1 ☐ Yes 2 ☐ No
	or 28,	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co United St	ountry?
	ath wi		14960 Greensbor			21636				America
	ltams	Funeral	T. Maria Ciara	2. Was Decedent I	Ever in U.S.	<ol> <li>Was Decedent of If Yes, specify Cub</li> </ol>	Hispanic Origin? (S pan, Mexican, Puer	pecify Yes or No o Rican, etc.)	14. Race - Ame Black, Whi	
336	Ir, or	by F	1 ☐ Never Married	1 ☐ Yes 2 ☑ 1 If Yes, Give Year or Dates:	40	1 ☐ Yes 2/€ No	Specify:		Specify:	casian
21215-0036	within 72 hours after death with the Maryland liene. r than "natural", or Itams 23a or 28a-1 show Its Medical Examirae must be natified at		15. Decedent's Educ (Specify only highest grade		16a. De	cedent's Usual Occu ve kind of work done	pation	rking	16b. Kind of Business	
21	⊆	Completed	Elementary/Secondary (0-12)	College (1-4or 5	life	. DO NOT use retire	ed)	ning.		
121			8 17. Father's Name (First, Middle, Last)		Sig	n Mechar		ne (First Middle	Adverti , Maiden Sumame)	sing
and	be do ava	o Be	Willey E	dward Ya	ates. Sr				ces Minni	sh
Maryland	d 2 should the and Ment 7 is marked traumatics	은	19a. Informant's Name/Relationship (Type						er, City or Town, State,	
	d 2 7 Is		Sharon Griffin	Daugl	hter 14	960 Gree	ensboro	Road,	Goldsboro	, MD 21636
ore	S = = 0		20a. Method of Disposition 1 🗆 Burial 2 🖫 Cremation 3 🗆 Re	emoval from State	20b. Place of Dis	position (Name of rematory or other pla	ace)	Date	20c. Location - City or	Town, State
Ë	Pages ment of ant: If it	1	`4 □Donation 5 □ Other (Specify)		Capito	l Cremat			Dover, De	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License	Mace					.A. 12 S.	2nd St.
			23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused e cause on each lin	the death. Do not no.	enter the mode of dy	ing, such as cardia	or respiratory a	rrest,	Approximate Interval Between
	Enysician	/ Ji	Immediate Cause (Final disease or condition	Septi	cemia					Onset and Death
	/Medical Examiner		resulting in death)	Due o (or as	a consequence of):	1				
		e.	Sequentially list conditions, b	. JGC U	a consequence of):	uestus				
	te be executed ysician and e burial-transit	Examin	Sequentially list conditions, if any section 1 mm dial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	hum.	a consequence of):					
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9	ificate g physi as the l				Contract of		/	- 6	)	
O. Box	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□ Unknown	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify)	cy		23d. Date of de Month	livery Day Year
Φ.	es that igned b be deta	by Pł	Part II. Other significant conditions con	tributing to death b	ut not resulting in the	underlying cause g	ven in Part I.	23e. Did t	obacco use contribute to	the cause of death?
Records,	w require been sig should b		Obstruction All	ep aps	men, M	while of	serity,	1,24	¥es 2□No 3□P	robably 4 Unknown
900	law re las be	Completed	decendations (	dirbete			1 ,	24a. Was	an 24b. Were a	utopsy findings available completion of cause of
œ.		Com						perfo 1 ☐ Yes	ormed? death?	2 □ No
Vital	ician: certific	Be	25. Was case referred to medical examiner?	ospital:		O	la mare	ath (Check only		
of	Phys rthis ral dii	- To	1 Yes No	28a. Date of Inju	ry 28b. Time	IBILL 3 DOA	4 🗆 Nursing F		dence 6 Other (Spe	cify)
O	th. : After	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year) Injur	y Wo	ork? ]Yes 2 ☐ No		,.,	
Division	al or Attanding Position of a safter death. If Diractor: After the funera	Certifications	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injuding, et	ury - At home, farm,	street, factory, office		28f. Location ( City or To	Street and Number or R	ural Route Number,
Ö	ital or rs afte af Dir led in	Cert	TO T	Daliding, 60				Ony or you		<u> </u>
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier Certifying Phys (Check only 2 Medicel Exemir one)	sicien: To the best ter: On the basis of and manner sta	f examination and/or	ath occurred at the t investigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To tha within 2 To tha complet	Ž	29b. Signature and title of certifier	1	100	29c. Licen	se number	,	29d. Date signed (Mont	h, Day, Year)
•			father la	un - Ah	while D	Ho	05687	5	May 23	2005
			30. Name and address of person who co		V		ld Town	Road	Goldsboro	, MD 21636
	Sta	te	Patricia . Kar 31. Date filed (Month, Day, Year)		ibel, DC ar's Signature	, 213 0.	La TOWII	noau,		, 115 21030
	Regist		MAY 2 3 2005	Marie a	H L	M. F				

DHMH 17 Rev 1/2001

Victoria Boudreaux Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department of Health And Mental Hygiene 1- State of Maryland / Department 05-3667 AKG 2 Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 9:38 P ictoria May 2005 Marie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Baltimore Harbor Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1□M 2\ F 219-88-2143 Yrs. Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits or 28a-f show traumatic avent, the Medical Exercities wast be notified at 1 ☐ Yes 2 ☐ No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with to nent of Heatth and Mental Hygiene.
ant: If item 27 is marked other then "natural", or items 23a or? 62 21225 U.5A ve 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waite ess ARMaid-17. Father's Name (First, Middle, Las) 18. Mother's Name (First, Middle, Maiden Sumame) Be 9 u 2 011 -aro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bomberg Cal 21221 Sherrie e other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of I Important: If its any injury or o once. 1 Burial 2 Cremation 3 Removal from State ` 4 ☐Donation ´ 5 ☐ Other (Specify) een Mount GeM 21. Signature of Funeral/Service/Licensee Newberry Ct Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Narcotic and alcohol intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine use as the burial-transit that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 W Unknown à signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2人☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ♥ es 2 □ No 24a. Was an certificate has autopsy 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 XXYes 2 □ No

Hospital or Attanding Physician: The law requires that the death certificate be executed Division of Vital Records. funeral director, page 2 should this Diractor: filled in by

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? unk 28d. Describe how injury occurred

1 ☐ Yes 2 XNo

28f. Location (Street and Number of Rural Soute Number City or Town, State) 521 Maude Avenue Baltimore, Maryland

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

5 Pending

investigation

6 X Could not be determined

29c. License number OCME

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

May 28, 2005

Baltimore, Maryland 21201

30. Name and address of person who completed cause o death (Item 23a) (Type, Print)

Leon

111 Penn Street M.D. eenbera

28a. Date of Injury 5—27-03

found

Year)

found at home

31. Date filed (Month, Day, Year) JUN 0 6

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 T Homicide

Certification:

Medical

State

Registrar

within 24 hours a

To tha

completely

28b. Time of

D

9:10 ury

found

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MP

Nelson M. Bruder 05-3786 AKG

3/E	56		101	partment of Health and I ertificate of Death	Mental Hy	giene Reg. No. 005   875
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Nelson M. Bruder			2, 2005 Year 12:28 P M
	Examir	ner	4a. Fecility Name (If not institution, give street and number) 5120 South Street — Patapsco Valley State Par	4b. City, Town, or Location of Death  K Catonsville	1	Baltimore County
	Funeral Director		5. Social Security Number 214-14-0174	ay) If Under 1 Year If Under 24 Hrs.	8. Date of Bi (Month, Di 11-4-	
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town o	Location		10d. Inside City Limits
	Maryi a-f eho	tor	MD Baltimore Catonsv			1 □ Yes 2 □ No
	or 28s	Direc	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?
	eath w	Funeral Director	1 Bristol Hill Ct Apt C3  11. Marital Status 12. Was Decedent Ever in U.S.	21228	posity Voc or Ne	U.S.A.  14. Race - American Indian,
920	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. item 27 is marked other then "natural", or Items 23a or 28a-f ehow other traumatic event, the Medical Examinar must be notified at	Ď	1 Never Married 2 Married 3 Widowed 4 Divorced  Armed Forces?  1 Married 1 Married 2 Married 1 Married 1 Married 2 Married 1 M	<ol> <li>Was Decedent of Hispanic Origin? (Splif Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 Ă No Specify:</li> </ol>	Rican, etc.)	Black, White, etc.  Specify: White
5-0	72 hc "natur	eted	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of work b. DO NOT use retired)	king	16b. Kind of Business/Industry
21215-0036	12 should be filed within h and Mental Hygiene. 7 Is marked other than traumatic event, The Me	Completed	Eigmentary/Secondary (U-12)   College (1-4or 5+)	em Operator		BGE
nd 2	e filed al Hygi I other vent, I	0	17. Father's Name (First, Middle, Last)	18. Mother's Nam		, Maiden Sumame)
ylaı	ould b	2	Milton Bruder	Theresa		
e, Maryland	is 1 and 2 sh of Health and item 27 Is m other traum		Marie Bruder/Wife 1 B	ristol Hill Ct Apt	C3 Cat	onsville MD 21228
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot			sposition (Name of rematory or other place)  ven Mem 1 Park 6-  22. Name and Address of Facility	Date 7-2005	Clen Burnie, MD
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate Cause (Disease or injury)  Due to (or as a consequence of):	V (7) (1) (1)	or respiratory a	rrest, Approximate Interval Between Onset and Death
O. Box 68760, ✓	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical Examine	That initiated events resulting in death) Last  C. Due to (or as a consequence of):  d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 □ Live birth 2 □ Fetel death	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
P.0	that the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did t	obacco use contribute to the cause of death?
rds	quires an sign uld be	ed by	-			Yes 2 🔼 o 3 ☐ Probably 4 ☐ Unknown
of Vital Records,		e Complete				
Ξ	Physician: 1 this certifical ral director, p	0 0	25. Was case referred to medical examiner?  1 XYes 2 □ No	26. Place of Deat ient 3 □ DOA Other: 4 □ Nursing Ho		dence 6 XOther (Specify) at scene
ion oi	nding th. : After s fune	ertification; T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  [Natural 5 Pending investigation]  [Natural 5 Pending (Month, Day Year)  [Natu	of 28c. Injury at Work?		how injury occurred
Division	al or Atter s efter dea al Director ad in by the	Certific	3 € Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Tol	Street and Number or Rural Route Number, wn, State) T, PATARS (O'VAUEYST PAKK, MO
	To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the	cause(s) and manner as stated.
	To the within 24	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
,	15		30. Name and address of person who completed cause of death (Item 23a) (Type			June 3, 2005
	10		31. Date filed (Month, Day, Year)  32. Begistrar's Signature	111 Penn Street	Baltim	nore, Maryland 21201
D	Sta Registr MH 17 Rev 1/20	ar	31. Date filed (Month, Day, Year)  32. Begistrar's Signature	Gentli		
חוט	*** 17 TEV 1/20	201	ORIGIN	IAL		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** June Charles Wilbur Beeker 2005 1:00 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City, Town, or Location of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Nov. 21, 1919 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 10**X**M 2□F Months Days Hours Min. Pennsylvania 85 217-05-3078 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. or Hems 27 is marked other then "naturel", or Hems 23s or 28s-f show 10b. Counts 10c. City Town or Location 10a State 10d. Inside City Limits 7 is marked other then "naturel", or items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Carroll Maryland Manchester Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3911 Calvins Twilight Way 21102 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 125 Yes 2 No If Yes, Give Year or Dates: WW II 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government Worker U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harvey Pleasant Beeker Helen Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3911 Calvins Twilight Way, Manchester, Md. 21102 Ruth Beeker - wife other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ permit. Page Department of Importent: If eny injury or once. Dulaney Valley Mem. Gardens June 7,2005 Timonium, Md. 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 3296 Charmil Dr. Manchester. Gentel L. Ole to 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final disease or condition resulting in death) estive **Physician** ma /Medical Due to (or as a consequence of): Examiner Sequentially list on efficient if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed and Due to (or as a consequence of): physician a the burial-1 Box 68760. Physiclan/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the detached 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. by 2 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion cause of death?

1 ☐ Yes 2 ☑ No 24a Wasan has autopsy certificate 1 ☐ Yes 2 No Vital To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After 1 Division 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident Director; 3 🗀 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 T Homicide n 24 hours a' 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Reistertern, MD 2/136 Jim Man 1(4 31. Date filed (Month, Day, Year) gistrar's Signature State JUN 0 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 12:00 A M **Blevins** Jean June 4 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7156 Gough Street Eastwood Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min. 1 □ M X□ F Yrs. Director 216**-**30-2154 7 1934 Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28a-f show any injury or other treumetic event, the Madical Examinat must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No X Director Maryland Baltimore Eastwood 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 7156 Gough Street 21224 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No þ If Yes, Give Year or Dates: Specify: 4 Divorced 3 Widowed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilbert M. Buchanan Ida C. Stambaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7156 Gough Street Baltimore, Maryland 21224 Carl J. Blevins ( Husband ) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Inc. June 6,2005 Baltimore, Maryland 22. Name and Address of Facility W. Dabrowski/Chojnacki Funeral Homes P.A. 1005 Dundalk Ave. Baltimore, Maryland 21224 21. Signature of Funeral Service Lig ash 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Emphysema Years /Medical Due to (or as a consequence of): **Examiner** Tobacco Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Years Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Box 68760 Physician/Medical as the t IF FEMALE 9SI 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 X No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2□No Division of Vital To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 0 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death | Director: / d in by the f 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Vithin 24 hours are To the Funeral Dir 1 🛣 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D38403 June 5,2005 30. Name and a less of person completed cause of death (Item 23a) (Type, Print) Howard Steiner MD 5601 Loch Raven Blvd. Baltimore, Maryland 21239 31. Dáte filed (Month, Day, Year) State JUN 0 6 2005

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Maryland		ent of Health and ate of Death		711115	18754
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	show	_	10a. State 10b. County	10c. City,	, Town or Location	1			10d. Inside City Limits
	8a-f s	Director		TIMORE	K	OSEDA	LE		1 Yes 2 No
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Baltimor	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service Licens	1/1 ) 11 '	22. Name	HHEM, PARK 06-	ROWNJR	. FUNER	AL HOME
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	bours hours uneral y filler		29a. Certifier 1 Certifying Phys	sician: To the best of my know	ledge, death occurr	ed at the time, date and plac	e, and due to the cause(	s) and manner as s	stated.
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1	Sta	ta.	31. Date filed (Month, Day, Year)	32 Registrar's Signatu	THE P	vica ruspilal,	. very prices		
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Registrar

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	State of Maryland / Department of Health and M  1 - State of Maryland / Department of Health and M  Certificate of Death	ental Hygiene 005 18756
	Registrar  1. Decedent's Name (First, Middle, Last)	Reg. No."  2. Date of Death  3. Time of Death
Physician /Medical	Gloria Nancy Casciero	June 2 2005 3: 46 AM
Examiner	4a. Facility Name (If not institution, pive street and number) 4b. City, Town, or Location of Death	4c. County of Death
	Mariner Health-Beltir Bel Air	Harford
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 8/14/1921 9. Birthplace (State or Foreign Country) Maryland
9	Usual Residence of Decedent	0/14/1921 Maryland
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siter death with the Maryland at thems 23e or 28e-f show diret must be notified at Funeral Director	MD Harford Bel Air  10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
3e or	426 Moores Mill Road Unit 1C 21014	U.S.A.
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Evantmer must be notified at once.  To Be Completed by Funeral Director	21. Signature of Funeral Service Licenson  22. Name and Address of Facility Mil  6415 Belair Road B	ler-Dippel Funeral Home Inc. altimore, Maryland 21206
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line.	r respiratory arrest, Approximate Interval Between
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,	) XIH MD D3465-	June 2, 2005
<u></u>	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Coff Has Will A North Avenue 8   Air  31. Date filed (Month, Day, Year)  32. Registrar's Signature	naryland 21014
State Registrar	31. Date filed (Month, Day, Year)  32. Registrar's Signature	/

State of Maryland / Department of Health and Mental Hygiene

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	TELD		Hugh O. de Fries	- Husband		3547 W	oodbin	e Road,	Woodbir	ne, Mary	land	2179	97
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Ĕ	Peges nent of ant: if its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	r)	Met	ropolita	n Crem	atorium	6/4/05	Alexand	ria,	Virg:	inia
Baltimore,	permit. Peges Depertment of Important: If its any injury or o		21. Signature of Fune II Service Licent	71.11	us)	Olin	L. Mo	ess of Facility lesworth				208	72
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	Physician /Medical		tmmediate Cause (Final									Onset and	d Death
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	D 0 0		27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Inju (Month, De	ry y Year)	28b. Time of Injury	28c. Inju		28d. Describe	how injury occur	red		
Sio	Attending or death.	cati	2 Accident investigetion 3 Suicide 6 Could not be					Yes 2 No	COA Leastion (	Street and Numb	or or Orani	Courte At	- hor
Division	or Att efter d Direct in by	Certification:	4 Homicide determined	28e. Place of Inj building, et	ury - At ho c. (Specify	rne, farm, street, t	actory, office		City or To		er or Hurar	House M	Imber,
_	To the Hospital or Attendin within 24 hours effer death. To the Funeral Director: Aft complately filled in by the fun	edical C	29a. Certifier (Check only one) 1 ☐ Certifying Ph. 2 ☐ Medical Exam	yelcian: To the best liner: On the basis of and manner st	examinat	wledge, death occion and/or investig	urred at the til gation, in my o	me, date and plece opinion, death occu	, and due to the trred at the time,	cause(s) and ma date and place,	inner as sta and due to	ated. the cause	∌(s)
	vithin o the	M	29b. Signature and title of certifier	0 1	20	:A A	29c. Licens	se number		29d. Date signe	d (Month, E	Day, Year)	)
	- s - ō		Allen	Keile	les	InD)	D54	749		June 3,	2005	5	
	1		30. Name and eddress of person who o		leath Item	23a) (Type, Print	)		1	Man-1	017	7.0.1	
	<u>')</u>		Allen Reilly M.				enue, l	D-1, Fred	erick,	marylanc	217	01	
	Sta Registr		31. Date filed (Month, Dey, Year)	32. Registr	10	South							

DHMH 16 Rev 6/95

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene () For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DiStefano Katherine 31, 9:10 A M 2005 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death National Lutheran Home Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral**  Birthplace (State or Foreign Country) Months 1 ☐ M 2 💢 F 219-18-8854 90 Director Yrs. Feb. 15, 1915 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelih and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~~\*\*\* any highly or other traumatic event. 10b. County 10c. City, Town or Location 10d Inside City Limits Md. Montgomery Rockville Director X□Yes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701- Veirs Drive 20850 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: White ģ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker At Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Webb Anabelle Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6410-New London Rd., New Market, Md. 21774 Janice Kulis-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State Parkwood Cemetery 6/6/2005 Baltimore, Md. ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicersee 22. Name and Address of Facility Hysong Co., Inc. W. solw 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Cardiac Dysrrthmias /Medical Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Due to or as a consequence of Examiner ed by the attending physicien and detached for use as the burial-transit requires that the death certificate be executed Aspiration Pneumonia that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Cardiac Obstructive Pulmonary Disease Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificete has performed? Yes 2 XNo 2 🗆 No 1 🗌 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 XNursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of Certification; 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deati To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6/1/2005 D 60612 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR ROCKVLLLE MD 9701- VEIRS MALLER SAMUEL 31. Date filed (Month, Day, Year) JUN 0 6 2005 Registrar's Signature Registrar

Robert Epps 05-03802 NJM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

I			For State Registrar	State of Maryland / Department / Ce.	artment of Health and rtificate of Death		ene g. No. 2005	18750
	Physici	an	1. Decedent's Name (First, Middle, Last	)	FOOL	2. Date of Death Month	Day Year	3. Time of Death
	/Medi Examir	cal	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Deat	<u>June</u>	3 2005 4c. County of Death	0856 <sup>M</sup>
1	Examil	lei	Northwest Regional		Randallstown		Baltimore	2
	Funeral Director		5. Social Security Number 6. Se		If Under 1 Year	8. Date of Birth (Month, Day, MARCIT		ace (State or Foreign
	yland		10a. State 10b. County	10c. City, Town or Lo	ocation		10	Od. Inside City Limits
	the Marylar 28a-f show	Funeral Director		TIHORE	GWYNN O	AK		1 Yes 2 No
	with t	Dir	10e. Street and Number	JOOD CIRCLE	10f. Zip Code	7	g. Citizen of What Coun	iry?
	ier death w Items 23a	nera	11. Marital Status		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puen	pecify Yes or No-	14. Race - America	
36	ours alter death with the Maryla at', or Items 23s or 28s-f shor Examit or must be notified at	by Fu	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XNo If Yes, Give	1 ☐ Yes 2 No Specify:	o Hican, etc.)	Black, White, e	itc.
Maryland 21215-0036		ted b	15. Decedent's Edu	Year or Dates:	dent's Usual Occupation	1	6b. Kind of Business/Ind	ACK
215	thin 7%	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) (Give	kind of work done during most of wo DO NOT use retired)	rking	_	
121	iled wi Hygien ther th		17. Father's Name (First, Middle, Last)	YR. EN	TREPRENUER	- Cina Middle M	STATE OF I	MARIKAND
lanc	2 should be liled withir and Mental Hygiene. is marked other than aumatic event, It a M.	To Be	JAMES	FPP<		PHINE	aiden Sumame)( 24 N -	CINKROWN
ary	should and Men s marke	F	19a. Informant's Name/Relationship (Ty	rpe, Print) 19b. Mailin	ng Address (Street and Number or Ru	ıral Route Number,		
	ges 1 and 2 should be illed within 72 ho t of Health and Mental Hygiene. If item 27 is marked other than "natur or other traumatic event, Ite M. dical		DIANE EPPS	(WIFE) 211	7 LAWNWOOL	S CIRCLE,	GWYNN OAK,	HD. 21207
altimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F		matery of ourier places)	-		1
iţi	permit. Pa Departmen Important: any injury		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service License</li></ul>		WN CEMETERY 06 -		WOODLAW	NMD.
B	Depa Impo any ir		Wetich.	N. Williams	TOSEPH HILL	NAVE	TR. FUNER BALTO. ML	21217
60,	rate be executed /Medical Examiner /Medical Examiner	il Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	tu Centiova	scula 1	4.	Approximate Interval Batween Onset and Death
68760,		edicai		i				
.O. Box	The law requires that the death certific tie has been signed by the attending p vage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of deliver Month	y Day Year
Δ.	es that igned b be deta	by PI	Part II. Other significant conditions cor	ntributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did toba	cco use contribute to the	cause of death?
ord	w require been sis	ted				1 ☐ Yes	2 No 3 Proba	bly 4. Unknown
Vital Records,		Completed				24a. Was an autopsy performe	prior to com death?	sy findings available pletion of cause of
<u>X</u>	yaician: is certilic director,	o Be	25. Was case referred to medical examiner?  1 □ Yes 2 □ No	lospital: 1  Inpatient 2 ER/Outpatien	0.4	th Check onl one)		
Division of	ing Ph	Certification; To	27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Injury	1 3 DOA 4 I Nursing H	ome 5   Residen	ce 6 Other (Specify) injury occurred	
Divis	or Att after d Direct d in by t	ertific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street building, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	ledical C	29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examin	i sician: To the best of my knowledge, death ner: On the basis of examination and/or inv and manner stated.	occurred at the time, date and place restigation, in my opinion, death occu	, and due to the cau rred at the time, date	se(s) and manner as sta and place, and due to t	ted. he cause(s)
	To the To the comp	M	29b. Signature and title of certifier	M	29c. License number OCME	290	. Date signed (Month, D	ay, Year)
i	4	-	30. Name and address of person who co	impleted cause of death (Item 23a) (Type,			June, 4, 200	)5
1	)				111 Penn Street	Baltimo	ce, Maryland	1 21201
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	22. Registrar's Signature	te de			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ALLEYNE F. ERRINGTON Month Year /Medical 2003 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GILCHRIST 10WSON BAL TIMORE CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2@F 214-38-1420 Director PENNSYLVANIA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If itam 27 is marked other than "natural", or itams 23a or 28a-f shoi injury or other traumatic avant, Ita Medical Erammer must be notified at Director 1 ☐ Yes 2 No MARYLAND BALLIMORE 10e. Street and Number 10g. Citizen of What Country? ENDALE KOAD 102 1.5, A 21234 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ⊆ Ze No If Yes, Give Year or Dates; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 ☐ Divorced Specify: WHILE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry iges 1 and 2 should be filed within it of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 1274 ACTIVITY DIRECTOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, JOHN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MR SAMUEL C. ERRINGTON HUSBAND 2 TO CLEMPALE KGAP

20a. Method of Disposition

20b. Place of Disposition (Name of semetery, crematory or other place) Date 20d. Location City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State <sup>1</sup> 4 □ Donation 5 □ Other (Specify) CARDENS OF PAITH CENETERY BALLIMORE MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of facility MARZULLO FUNERAL CHAPEL P.A. BALTIMORE, MARYLAND 6009 HARFERD KCAD 23a. Part1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Breast Concer metastatic year /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy Vital 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No <sup>2</sup> 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: Attanding 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide To the Hospital or within 24 hours a

To tha Funaral E

completely filled i Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

JUN 0 6 2005

32. Registrar's Signature

6-Binte

N. Chroles

29d. Date signed (Month, Day, Year)

				State of M	aryland /		rtment of F tificate of		mental Hy	giene	C 4123	
		-	Decedent's Name (First, Middle, La.	st)		Cer	incate of	Deam	2. Date of De	Reg. No.	U5	3 Time of 5-64
	Physic	ian	Catherine C. I	•					Month	Dey	Year	S. Time or beam
Q.	/Medi		4a Facility Name (Il not institution, give					4b. City, Town, or	Location of Deat		0 5 of Death	7:30 AM
~	Exami	ilei	St. Martin's H					Catonsv				•
	Funeral		5. Social Security Number 6. S		e (In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bir		timo: 9. Birthp	lace (State or Foreign try)
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	/land		10a. State 10b. County		10c. City, To	own or Loc	ation				1	Od. Inside City Limits
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	7 28 x	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V	What Coun	try?
	23 vil	<u>a</u>	601 Maiden Choice	e Lane			21228			τ	ISA	
	8	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U,S.	13. W		lispanic Origin? (S an, Mexican, Puer	Specify Yes or No		e - Americ	
21215-0020	within 72 hours after death with the Maryland ene. than "naturel", or itema 23e or 28e-f ehow ha Medical Examiner must be notified at	Completed by Fu	1 ☐ Never Married 2 ☐ Married 3 🛱 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ 1 If Yes, Give Year or Dates:			□ Yes 2 No	Specify:		Specify		ite
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2	2 should I and Meni le market aumatic	5	19a. Informent's Name/Relationship (1	(vne Print)	1	9b Meiling	Address /Street	and Number or Ru		er City or Town	State Zin	Code)
			Sr. Catherine M. H					Avenue,				,
Baltlmore,	ges 1 and t of Health If Itam 27 I or other tr		20a. Method of Disposition	-	20b. Place	of Dispos	ition (Name of story or other place		Date	20c. Location -	-	
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aĦ	permit. Pa Departmen Important: eny Injury pnce.		21. Signature of Funeral Service Licen	see . O		_	Name and Addre			Tuneral		
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			23a. Part1. Enter the disease, or comp shock, or heart tailure. List only	olications that caused	the death. D	o not ente	the mode of dyin	g, such as cardiad	or respiratory a	rrest,	1	Approximate Interval Between
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	/Medical Examiner		Immediate Cause (Final disease or condition resulting in deeth)	a LO	WER	G	ASTRO	INTE	STINA	L		ONE DAY.
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-	the a	ysic	Part II. Other significant conditions co	ntributing to death bu	t not resulting	j in the und	lerlying cause give	en in Part I.	23b. Did	lobacco use cor	tribute to	the cause of death?
P.0	that the de sed by the a detached	된	CHRONIC OL	STRUC	TIVE	4	NG DI	ISEASE	10	Yes 2□ No	3 ☐ Prob	ably 4 Unknown
ds	uires sign	g p								an autopsy	24b. We	re autopsy findings
20	law requires that the death cert iss been signed by the attendin s 2 should be detached for use	olete	MULTINDOWAR	THYR	DID CIE	101T	RE			rmed?	con	ilable prior to apletion of cause eath?
of VItal Records,	0 - 0	Completed	ADRTIC STE	. 2120V					101	res 2000		Yes 2□ No
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2	Physician; this certific rai director,	ဥ	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2□ER/0	Outpatient	3□ DOA Oth	475 Nursing H	ome 5□ Resid	dence 6 □Oth	er (Specify	)
Ë	tanding P death. tor: After t	Ë	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injur (Month, Da)	Year) 28b	i. Time of Injury	28c. Injun Won		28d. Describe I	now injury occurr	ed	
<u>8</u>	Attending or death. actor: After by the fune	Cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	Inv - At home	farm ctro	200	Yes 2 □ No	29f Location /	Street and Numb	or or Pural	Poute Number
Division	or Attand after death Director: A	Certification:	4 ☐ Homicide determined	building, etc	. (Specify)	iann, suec	n, raciory, omce		City or Tov		or or ridiar	riodie ridinosi,
	papita hours neeral y filled	2	29a. Certifier 1X Certifying Phy	sician: To the best of	f my knowled	ge, death o	occurred at the tim	e, date end place	, end due to the	cause(s) and ma	nner as sta	ited.
	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th	edical	(Check only 2 Medical Exam	iner: On the basis of and manner sta	examination a ted.	and/or inve	stigation, in my of	oinion, death occu	rred at the time,	date and place, e	and due to	the cause(s)
	Tot some	2	296. Signature and title of certifier	Day			29c. License			29d. Date signed	1	ay, Year)
	1	1	* Kanal li	- Kary	)		DIS	3362		0/2/	55	
	U '		30. Name and address of person who c	The second secon		i) (Type, P	43	. Suite 3	208 · R	alto	Md2	22 0
	Sta	te.	31. Date filed (Month, Day, Year)		r's Signature	TIME	M 1115	. 500. 40 3		-0110.	F 101 €	,
	Registr			0 6 2005	6							
DHI	AH 16 Rev 6/95	5	JUN	U 0 4000	ALIEUS.	10	Lossel	-				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey 2005 Month **Physician** 2:25 Morgan Guee une /Medical 4b. City, Town, or Location of Deeth RandalStown 4c. County of Deeth
Ballimor 4a Fecility Name (If not institution, give street end number) Examiner where Care old Cour NURSINA If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Clyntry) Mary and 5. Social Security Number 7. Age (In yrs. last birth gay) **Funeral** -16-9740 Months Devs Hours 100 M 2□ F Yrs. Director Usuel Residence of Decedent filed within 72 hours after deeth with the Meryland 10a Stete 10b Counts 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 25s-f show other traumatic event, the Medical Examinar must be notified at 1 PYes 2 □ No yanland Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 604 Winans Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status Black, White, etc 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Ą 3 ☐ Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. ntery/Secondary (0-12) College (1-4or 5+) abore Grade 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked or Isaac Ghee ouise 2207 19b. Mailing Address (Street and Number of Rurel Route Number, Ci 19e Informant's Name/Relationship (Type, Print) Howard -niece ladene tanne 20b. Place of Disposition (Name of cometery, cremetory or other)

Drud Ridge 20c. Location - City or Town, State Date 21208 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State ò 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee lan 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one ceuse on each line. **Physician** Immediate Cause (Final /Medical 0 disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physicien end s the buriei-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of): tor: After this certificate has been signed by the attending p the funeral director, page 2 should be detached for use es Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Dld tobacco use contribute to the cause of death? 3 Probably 4 Unknown 2 No þ 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Was en autopsy performed? Be Completed 2 ₽No 1 Tes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpetient Medical Certification: To 1 Yes 2 □ No 1 Inpatient 3□ DOA 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Death 5 Pending investigation 1 Natural 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospitai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steled.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steled. completaly To the 29d. Date signed (Month, Dev. Year) 29c. License number 29b. Signature end title of certifier Ġ 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 000 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State 0 6 2005 Registrar

**ORIGINAL** 

**DHMH 16 Rev 6/95** 

			1 - State Registrar		C	ertifica	te of [	Death			Reg. No.	0 50	a programmy	a 0
	Dharini		1. Decedent's Name (First, Middle, Last)	_						2. Date of De	eath Day	JUJ	3. Time of De	ath)
	Physici /Medio		ISRAEL	LI	EON	GLAS:	SGOLD			May	31	Z007	9:13	РМ
	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City	, Town, or	Location o	f Death	, J	4c. Cou	inty of Death	·	
			Sinai Hospital	of Bo	iltimore	_ 150	iltim		Ci	ty			N/A	
	Funeral		5. Social Security Number 6. Sex		(In yrs. last birtho	Months	or 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 0CT.14	th ly, Year)	9. Birthp	lace (State or F	oreign
	Director			M 2 F	81 Yrs					OCT.14	,1923		PA	
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location			···				0d. Inside City I	Limite
	larylis sho	5			•		r <del>-</del>					'	1 X Yes 2	
	Ne N	ect	MD N/A		DAL	TIMOR								
	with 1	ä	10e. Street and Number	Б		101. 2	ip Code	0100			10g. Citizen	of What Cour	•	
	eath	era	6101 BENHURST ROA	D 2. Was Decedent B	Suprin II C	2 Mac Dec	ada at at litie	2120			141	Race - Americ	USA	
	Henri Item	Funeral Director	11. Marital Status 1. Never Married 2 1 Married 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	Armed Forces?		If Yes, sp	ecify Cubar	n, Mexican,	, Puerto F	cify Yes or No Rican, etc.)		Black, White,		
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or itema 23a or 28e-f show the Medical Examinatinational Le notified at	by	3 ☐ Widowed 4 ☐ Divorced	1 MYes 2 N If Yes, Give Year or Dates:	Wit	1 🗆 Yes	2 🔀 No	Specify:			Spe	ecify:	WHITE	
Ŏ	2 ho	Completed	15. Decedent's Educ		16a. De	cedent's Us	ual Occupa	tion	, ,,		16b. Kind o	of Business/Ind	dustry	
2	hin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	- III	ive kind of w e. DO NOT			or workir	1g				
2	giene giene er thu	Corr	5	+	ENG	INEER					CIVI	L		
D	al Hy al Hy al oth	Be (	17. Father's Name (First, Middle, Last)					18. Mother	r's Name	(First, Middle	, Maiden Sun	name)		
<u>Va</u>	Ment Ment arked	으	SOLOMON	S.	GLASS	OLD		ANN	Α				BLAUKO	PF
Maryland	and and ls m		19a. Informant's Name/Relationship (Typ			-						wn, State, Zip	Code)	
	and ealth m 27 ner tr		IRIS J. GLASSGOLD	/ WIFE	_	1 BEN		ROAD		ALTIMO				
O.	of H if ita		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Re	moval from State	20b. Place of Di cemetery,	sposition (Na crematory or	ame of other place	)	D	ate	20c. Location	on - City or To	wn, State	
Ē	men tant: jury		`4 ☐ Donation 5 ☐ Other (Specify)		CHIZUK A							LTIMOR		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28e-f show any injury or other traumetic event, the Medical Examination at Legical Examination and once.		21. Signature of Funeral Service Licenses									BROS.,		
	7D = 6 0		the sure	~		8900	REIST	ERSTO	WN R	0AD - 1	PIKESV	ILLE, N	MD 21208	3
П			23a. Part 1. Enter the disease, or cont plic shock or heart failure. List only one	cause on each lin	the death. Do not e.	enter the mo	de of dying	, such as o	cardiac or	respiratory a	rrest,		Approximate Interval Betwee	en
8	Pnysician		Immediate Cause (Final disease or condition	Preu	monia								Onset and Dea	1.S
Н	/Medical Examiner		resulting in death)	Die to (or as a	consequence of):	YW								
	LAdiffile	_	Sequentially list conditions, b.	Care	bral	thro	Mbo	Sis					3 MON-	ths
	sit 9d	ine	dany, leading to immediate cause. Enter Underlying Cause (Disease or injury	Use to (or es a	i nonsoquenna of):									
	ecut and I-tran	Examiner	that initiated events c. resulting in death) Last	Due to (or as a	consequence of):									
90	be exician ician buria	田田田		200 10 (0) 20										
68760	certificate be executed iding physician and ise as the burial-transit	/Medical	d.				-			<del></del>	~		_	
×	certif iding ise as		IF FEMALE:	c. If yes, outcome of	of pregnancy						224	Date of delive		
å	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at		3 Ectopic p 5 Other (s							Day Yea	ιf
P.O.	y the	Physiciar	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		0	,pccy/							
	w requires that the death oben signed by the attenshould be detached for u	Y P	Part II. Other significant conditions conti	ibuting to death bu	t not resulting in th	e underlying	cause give	n in Part I.		23e. Did t	obacco use c	ontribute to th	e cause of deat	th?
sp.	ulres 1 sigr 1d be	d by	Chronic atri	al fi	brille	tion				1 🗆 '	Yes 2 No	3 ☐ Prob	ably 4 🗆 Unk	nown
00	w req beel shou	Completed	H actancia							24a. Was	an 24	h Were autor	osy findings ava	ulahle
Re	he ta s has ge 2	щ	Figher Cents (b)	Y\						autor	osy rmed?	prior to con death?	npletion of caus	e of
a	ificate or, pa	e Cc	25. Was case referred to medical	ey				00 П	at Danah	1 Yes	2 No	1 🗆 Yes	21 <b>X</b> No	
5	s cert irect	00	examiner?	spital: 1   Inpatier	nt 2 ER/Outpa	tient 3 D	Other			(Check only o		Other (Specify		
ō	Phy er this eral d	J: To	27. Manner of Death	28a. Date of Injury (Month, Day			28c. Injury Work			8d. Describe			7	
on	th. :: Afte	tiol	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Inju	y M		? es 2□N	10					
Division of Vital Records,	Atter r dea actor by the	ifice	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		ry - At home, farm,	street, facto	ry, office		2			mber or Rura	Route Number	,
	s afte	Certification:	4   Homicide	building, etc.	. (Зреспу)					City or To	wn, State)			
	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  within 24 hours after death.  completely filled in by the funeral director, page 2 should be detached for a completely filled in by the funeral director, page 2 should be detached for a completely filled in by the funeral director, page 2.		29a. Certifier 1X Certifying Physic (Check only 2 Medical Examine	cian: To the best o	f my knowledge, d	eath occurred	at the time	e, date and	place, a	nd due to the	cause(s) and	manner as st	ated.	
	in 24 in 24 iha F plete	edicai	(Check only 2 Medical Examine one)	and manner stat	ed.	investigatio	n, in my opi	mion, dead	n occurre	d at the time,	date and plac	e, and due to	tne cause(s)	
	P M P O	Z	29b. Signature and title of certifier	0/1	1		c. License	number	. 0		29d. Date sig	ned (Month, L	Day, Year)	_
./	1		Cindy	X mm +	tung	MI	PA	5 -	170	150	May	31	2005	
11			30. Name and address of person who com	pleted cause of de	ath (frem 23a) (Ty	oe, Print)	11		1	0	- 7	<i>f</i> :		
1			31. Date filed (Month, Day, Year)	32 Pagistra	r's Signature	lai	1-10	Spir	tal	64	13at	timo.	76	
	Sta Registr			A Comment	L Z	1	î	1		1				
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				-										

			For	State of M	laryland			Health and	Mental Hy	/giene	000	\$ prog assess on
			State Registrar			Ce	rtificate of	f Death		Reg. No	105	18/64
	Physici	an	1. Decedent's Name (First, Middle, L	·					2. Date of D Month	Day	Year	3. Time of Death
	/Media	cal		erson	4		AL CIL Town	1	June		2005	5715 MM
	Examir	ner	4a. Facility Name (If not institution, gi		)		0 11	or Location of Dea	th \	4c. Cour	ity of Death	
	Francis		5. Social Security Number 6.		ge (In yrs. Ia	st birthday	If Under 1 Year	r If Under 24 Hr	s. a. Date of Bi	rth.	9 Birth	place (State or Foreign
2	Funeral Director		216-14-0903	1□ M 2 🛣 F	83	Yrs.	Months Day	s Hours Mir	10/02	ay, Year)	L	place (State or Foreign intry)
50			Usual Residence of Decedent		05		<del></del>		10/02/	/1921	Mary	Land
2	fanylan show		10a. State 10b. County		10c. City,	Town or L	ocation					10d. Inside City Limits
2	a Ma	cto	Maryland Maryland		Ba	Ltimo	re					1√ Yes 2 No
7	death with the Maryland ms 23a or 28a-f show I must be notified at	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o		intry?
N	s 23a	rai	3018 Fallstaff M	anor Court	Apt.	E1		209		U.S		
13	after dea or Items	Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent	2		If Yes, specify Cu	Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or N rto Rican, etc.)	0- 14. H	ace - Ameri lack, White	
36	irs afi	by	3 Midowed 4 □ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			1 ☐ Yes 2 ☐ N	o Specify:		Spec	ify: B	lack
IN O	be filed within 72 hours after death with the Maryla Ital Hygiene. of other then "naturel", or fems 23a or 28a-f show event, I're Medical Examinat must be notified at		15. Decedent's E	Education		16a. Dece	dent's Usual Occ	upation		16b. Kind of		
275	within 72 ene. then "nat	Completed	(Specify only highest gi	rade completed) College (1-4or	5+)	(Give	kind of work don DO NOT use retii	e during most of wo red)	orking			•
2 2	giene giene	Com	8			Elev	ator Ope	rator		Court	House	e
4 2	al Hy al Hy d oth	Be (	17. Father's Name (First, Middle, Las	<i>t</i> )			•		me (First, Middle			
3 🗷	Ment Ment arked	0	Artis Leathe					Viola C	ornish			
Maryland	2 sho and Is m		19a. Informant's Name/Relationship					et and Number or F				,
75	and lealth m 27		Laura Mahalale-El	. / Daughte				e Avenue				
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then eny injury or other traumatic event, Ita Magnee.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [		9		osition (Name of matory or other p		Date	20c. Location	,	
₽₽	t. Pa tmen tent: jury		*4 ☐ Donation 5 ☐ Other (Spec		Balt	imore	_Nat'1 C	eme. 06/0	07/2005	Catonsv	ille,	Maryland
Bal	permi Depar Impor eny ir		21. Signature of Funeral Specice Lie					ress of FacilityThe				
0			23a. Part1. Enter the disease, or cor	polications that cause	od the death						Mary	land 21215 Approximate
			shock, or heart failure. List only	y one cause on each l	line.							Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a Chron	الد د	rodu	mothe	Dulma	y dise	wse_		15 years
	Examiner			Due to (or as	s a conseque	ence of):			1			ı
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	s à conseque	ence of):						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C								
ó	an an rial-tr		resulting in death) Last	Due to (or as	s a conseque	ence of):						
68760,	iicate be executed physician and s the burial-transit	edicai		d								
		Med	IF FEMALE:				-					
Вох	eath certifi attending for use as	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			∃Ectopic pregnan	су		1	ate of deliv	,
	at the dea by the at tached fo	Physician/M	1 Yes 2 No	4□Pregnant a 9□ Unknown	at time of dea	ath 5[	Other (specify)			IV.	lonth	Day Year
P.0	The law requires that the death certif ate has been signed by the attending bage 2 should be detached for use a		Part II. Other significant conditions	contributing to death	but not recul	ting in the u	ndorhing on on	uron in Cort I	330 Did	labassa usa sa	nteibuto to t	he cause of death?
Š,	ires tha signed I	by	Communications	Le - a l		.~0	moenying cause g	iveri ili Falt I.				pably 4 ⊋Unknown
0.0	w require been sig should b	etec		,	30010							
Jec	has ge 2 s	ompieted	by/words a	yperter	260 1	7			24a. Was		prior to co	opsy findings available impletion of cause of
<u>a</u>	icien; The certificate h rector, page	O	·						1 ☐ Yes	2 <b>Y</b> No	1 Yes	210 No
Division of Vital Records,	Physicien; rthis certifica ral director, p	o Be	25. Was case referred to medical examiner?  1 ☐ Yeş 2 ☑ No	Hospital:	2005	D/O		thor	ath (Check only			
of	Phys ir this aral dii	<b>—</b>	27. Manny r of Death	28a. Date of Inj. (Month, Da		P/Outpaties 28b. Time o			Home 5 Resi	how injury occu		ý)
on	Attending For death.  ector: After by the funera	tion	1		ay Year)	Injury		ork? ⊒Yes 2⊟No				
N. S.	I or Attendi after death. Director: A	Hice	3 ☐ Suicide 6 ☐ Could not l	28e. Place of In	ijury - At hon	ne, farm, st	reet, factory, office	9	28f. Location (	Street and Nun	ber or Rura	al Route Number,
Ö	s afte	Certification;	4 Tromicide	bullaing, e	tc. (Specify)				City or To	wii, State)		
	lospit hour uner	edical	29a. Certifier 1 Certifying P	hysician: To the best miner: On the basis	t of my know	ledge, deat	h occurred at the	time, date and plac	e, and due to the	cause(s) and n	nanner as s	tated.
	To the Hospitel or Ati within 24 hours after d \To the Funerel Direct completely filled in by	Medi	one)	and manner s	tated.				urred at the time,			
	No. No. No.	-	29b. Signature and title of certifier	00	1 1		Sac. Fice	nse number	. (~	29d. Date sign		
	7	1	20 Name and address of second	completed assess of	doub (ltax)	220\ / 7:	1 65	-2-00		Sura	3,	2005
4			30. Name and address of person who	Table 2	M. M		piner L	1 4000	220	112	at =2	2005
	Sta	te	31. Date filed (Month, Day, Year)	32. Egist	rar's Signatu	E -	Carte o	Shorter 1	0 0	XX I VIII	100	
	Registr	ar	JUN 0 6.	2005	ير معن	1	- CA					

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland		ertificate of			giene 20	05	18765
ı	Physici	an	1. Decedent's Name (First, Middle, Last) Wilson	Jenkins		-		2. Date of De		Year	3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give of the facility Name of the	eral HOSpita	asi birthday Yrs.	Baltin	r Location of Death	8. Date of Bir (Month, Da Dec . 13	4c. County o		ce (State or Foreign
	D		Usual Residence of Decedent  10a. State 10b. County		. Town or L	ocation	1	pcc. 13	, 1525		d. Inside City Limits
	e Maryl	ctor	Md.	Bal	timo	re					1 Yes 2 □ No
	with the	Director	10e. Street and Number	-		10f. Zip Code 21225			10g. Citizen of Wi	hat Countr	y?
336	us after death al', or Items 23	by Funeral	2434 Seabury RC  11. Marital Status  1 Never Married 27 Married  3 Widowed 4 Divorced	Dad  12. Was Decedent Ever in U.S Armed Forces?  ★(Tytes 2 □ No 174s, Give Year or Dates:	S. 13.	. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		American White, et	c.
9200-91212	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Exam harming the molified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary(Secondary (0-12)		(Giv	edent's Usual Occup e kind of work done o DO NOT use retired aborer	ation during most of wor t)	king	16b. Kind of Bus		•
yland 2	should be filed nd Mental Hygi marked other imatic event, i	To Be (	17. Father's Name (First, Middle, Last) Harry Jenkins				18. Mother's Nam		Maiden Sumame itts Jen		5
Mary	12 ha 7 Is		19a. Informant's Name/Relationship (Ty Esther Robinson		19b. Mail 3113	ling Address <i>(Street a</i> Windsor	and Number or Ru Ave., Ba	ral Route Numberalto.Md	er, City or Town, S l . 21216	tate, Zip C	code)
Baltimore,	Pages 1 and nent of Heelt int: If item 2 iry or other		20a. Method of Disposition 1 [XBurial 2 □ Cremation 3 □ R 1 1 □ Donation 5 □ Other (Specify)	lemoval from State	metery, cre	position (Name of ematory or other place on Forest	· 1	Date O5	20c. Location - C		
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License			22. Name and Address 12 Third			_		-
	Enysician /Medical	(	23a. Part 1. Enter the assass or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	aPneumo	nia		g, such as cardiac	or respiratory a	rrest,	I.	opproximate Interval Between Onset and Death
√ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	te be executed was an and wasician and buriat-transit	dical Examiner	Sequentially list and liters if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	School of the desired C	erosis C hronic			disease	2	,
O. Box 6	at the death certifice by the ettending pt tached for use as tt	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dei 9 ☐ Unknown	death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Monti		ay Year
ecords, P	ires the signed d be de	by	Part II. Other significant conditions con	ntributing to death but not resul	lting in the I	underlying cause give	en in Part I.		obacco use contrib ∕es 2□No 3	oute to the	
r	The law ste has b page 2 sl	Completed	Diabetes type	I				24a. Was autop perfo 1 \( \text{Yes} \)	pri rmed? pri de	or to comp ath?	y findings available pletion of cause of
VII	ysicien: The is certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 ☐ Inpatient 2 ☐ E	B/Outnatie	ent 3 DOA Othe	26. Place of Dea		ne) dence 6 ☐Other	(Cassifu)	
lon or	ding Ph After th funeral	F 4	27. Manner of Death  1 Matural 5 Pending 2 Accident investigation		28b. Time o Injury	of 28c. Injury Work			now injury occurred		
UIVISION	e Hospitel or Attend 24 hours efter death 25 Funerel Director: etely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, si	treet, factory, office		28f. Location (5 City or Tox	Street and Number vn, State)	or Rural F	Route Number,
	To the Hospitel or A within 24 hours efter To the Funerel Directompletely filled in by	edicai	29a. Certifier 1 Certifying Physics (Check only one)	sician: To the best of my knowner: On the basis of examination and manner stated.	rledge, dea on and/or in	th occurred at the tim nvestigation, in my op	ne, date and place, pinion, death occur	and due to the cred at the time,	cause(s) and manr date and place, an	ner as state d due to th	ed. ne cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	V		29c. License	number		29d. Date signed (		
	1		30. Name and address of person which	pleted cause of death (Item	23a) (Tyne	Print)	228		5-aq Hospit	3-0	5
	3		Yinghua Lia	ng m.b. 01	o M	aryland	1 Gene	ral	Hospit	al	
	Sta Registr	-	31. Date filed (Month, Day, Year)  JUN 0 6 20	32. progistrar's Signatu	K A	books			,		

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			State of Maryland / Department of Health a		-	_	10777
			1 - State Registrar Certificate of Death		Reg. N	2005	18/66
	Physici	an	1. Decedent's Name (First, Middle, Last)	Mo		ay Year	3. Time of Death
	/Medic	čal.	CLARENCE JOHNSON  4a. Facility Name (If not institution, give street and pumber) , , , , , , , , , , ,	of Death		Ic. County of Death	9.00
	Examir	ier	Franklin Square Hospital Rused	lale		Baltil	nave.
	Funeral		5. Social Security Number 6. Sex 7 Age (In yrs. last birthday) If Under 1 Year If Under	Min. (Mo	e of Birth orth, Day, Yea	r) Coui	place (State or Foreign
	Director		218-44-5400 XX Page 157 Yrs. Months Days Hours Usual Residence of Decedent	02	2/24/1		RYLAND
0)	yland yland		10a. State 10b. County 10c. City, Town or Location			1	Od. Inside City Limits
C	in Z i 3-0030 within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28a-f ahow ta Madical Evenifier must be notified at	Director	MD BALTIMORE ESSEX				1 ☐ Yes 2 ☐ No
10	with th	Dire	10e. Street and Number 10f. Zip Code		10g. C	Citizen of What Cour	ntry?
5	leath w ns 23e	Funeral	5 EDDYSTONE PLACE 21221  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ori	igin? (Specify Ye		Sa 14. Race - Americ	can Indian,
1/2 "	after dea or items		Armed Forces? If Yes, specify Cuban, Mexican  1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No		etc.)	Black, White,	
<u></u>	ural',	d by	Year or Dates:	·		Specify: BL	
u	in 72	olete	15. Decedent's Education (Specify only highest grade completed)  [Give kind of work done during mos life. DO NOT use retired)	st of working	16b.	Kind of Business/In	dustry
25	7 7 7 C	Completed by	College (1-4or 5+)   10TH   LABORER			CONSTRUC	CTION
S	be filled ital Hygis of other	Be		er's Name (First,		en Sumame)	
2	Mer Mer atic	2	LAWRENCE JOHNSON	BESSIE	ROB	INSON	Codel
0 5	t The E		19a. Informant's Name/Relationship (Type, Print)  DERRICK D. JOHNSON / SON 7511 STONECUTTE				
17	es 1 and of Health filem 27		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	APT E	BALTIN Location - City or To	own, State
,	Pages ment of I		1 ☐ Burial 2X Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)  METRO CREMATORY	6/4/05	C	ATONSVII	LLE, MD
200	partillore, permit. Pages 1 s Department of He Important: If item any injury or othe		21. Signature of Juneral Service Licensee 22. Name and Address of Facility	110112			ME 21207
			23a. Parts: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, head failure. List only one cause on each line.	Y HEIGH	TS AV	E, BALTI	Approximate
	Physician		Immediate Cause (Final	Mark	han	0	Interval Between Onset and Death
	/Medical		disease of condition resulting in death)  Due to (or as a consequence of):	-11011	nag		
	Examiner	L	Sequentially list conditions, b. Izenal Fallure				
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	ite be executed ysician and ne burial-transit		that initiated events c. resulting in death) Last Due to (or as a consequence of):				
0220	3 2 9	Ical	d				
9	eath certificat attending phy	Physiclan/Med	IF FEMALE: 23c. If yes, outcome of pregnancy				
9	atten atten	clan	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 4 Fedal death 3 Ectopic pregnancy 5 Other (specify) ————			23d. Date of delive Month	Day Year
	by the attached	hysi	9 ☐ Unknown 9 ☐ Unknown				
	res that igned to be deti	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	l. 23		use contribute to the	
obygood letty to acioivid	w requir been si	eted			1 ☐ Yes	2 □ No 3 □ Prob	ably 4 Unknown
	The taw cate has b	Completed		24.	a. Was an autopsy performed?	24b. Were auto prior to con death?	psy findings available mpletion of cause of
	vician: Th ician: Th certificate ector, pag	a)	25. Was case referred to medical 26 Place	e of Death (Chec	Yes 2 N	lo 1 Yes	2□ No
;	yaician: yaician: lis certific director,	To B	examiner?			6 ☐Other (Specify	v)
9	ding Phy h. After thi funeral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 48c. Injury at Work?		scribe how inj	ury occurred	
	Attendia death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be determined experiment and suicide 1 Suicide 1 Suicide 28e. Place of Injury. At home, farm, street, factory, office		ation (Street a	and Number or Rura	I Boute Number
.2	spital or Attencours after death	Certification;	4 Homicide determined building, etc. (Specify)		or Town, Sta		a riodie radioer,
	To the Hospital or Attending Phyaician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phyainetely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2.	edical C	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, dea				
	To the Hos within 24 hd To the Fun completely	Medi	one) and manner stated.				` '
	P ₹ 0 0		250. Signature and the ori capital and the original and t	e Z	250.0	61,105	oug, rour)
	2 1	T	30. Name and address of person who completed cause of death (Item 23a) (Tyge, Print)		0	1	/
(	<del></del>		Dr Dawei Yang 9000 Franklin Square I	Inve	Balt	More,1	Md 21237
	Sta Registi		31. Date filed (Month, Day, Year) 2005 Registrar's Signature JUN 0 6 2005			/	

			For Stata Registrar		State of	Marylaı		artment of F		nd Mental Hy		2005	1876
			Decedent's Name (	First, Middle, Las	t)			711110410 01	Douin	2. Date of D	Rag. No. eath		3. Time of Death
П	Physici		DORFT	HA. K	THIE					JUNE	Day	2005	2:52 PM
	/Medic Examir		4a. Facility Name (If no		street and nun	nber)		4b. City, Town, o	r Location of D		4c.	County of Death	12.72
	Exami		UNIVERSITY	OF MAR	" Class	MEDICAL	- CENTIE	BALT	MORE	=		NA	
	Funeral		5. Social Security Num	nber 6. S	×	7. Age (In yrs		If Under 1 Year	If Under 24	Hrs. 8. Date of B	irth	9. Birth	place (State or Foreign
L	Director		238-28-81	66	⊐м 2√2 г	84	Yrs.	Months Days	Hours	Min. (Month, D		Cou	N.C.
	P >		Usual Residence of D			10.0							
	aryla shov	5	_			106. 0	ity, Town or L						10d. Inside City Limits 1 Yes 2 ☐ No
	he M	ectc	Md.	NA			ват	timore					
	th with t	<b>Funeral Director</b>	10e. Street and Numb		•			10f. Zip Code 212	13		10g. Citiz	zen of What Coul USA	ntry?
	dea	ner	11. Marital Status		12. Was Dece Armed For	dent Ever in U	J.S. 13.	Was Decedent of H	lispanic Origin	? (Specify Yes or N	0- 1	4. Race - Americ Black, White,	can Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "naturel", or Items 23e or 28e-f show any injury or other treumatic event, its Modical Eventrier must be notified at once.	by	1 Never Married 3 Widowed 4		1 ☐ Yes If Yes, Giv Year or Da	2 [ <b>X</b> No e		1 ☐ Yes 2 ☑ No	Specify:	dono maan, oto.,			.ack
Ŏ	2 ho	Completed		5. Decedent's Ed			16a. Dece	dent's Usual Occup	ation		16b. Kir	nd of Business/In	dustry
215	thin 7 en "n Mad	ple	Elementary/Second	only highest gra ary (0-12)	College (1	-4or 5+)	life.	kind of work done DO NOT use retired	during most of d)	r working			
	ad wil	50	10th				Ma	intenance			Se	ears	
p	al Hy	Be (	17. Father's Name (Fit	rst, Middle, Last)					18. Mother's	Name (First, Middle	e, Maiden S	Sumame)	
yla	Meni Meni	ပ	Roger			ì	Mills		Mar	rtha	D.	Luc	as
Maryland	2 sho and Is m		19a. Informant's Nam-	. ,	ype, Print)		19b. Mail	ing Address (Street	and Number o	or Rural Route Numb	er, City or	Town, State, Zip	Code)
	and ealth m 27		Donald K		Son				Ave.,	Baltimore			
Ore	ges 1 r of H if ite		20a. Method of Dispos 1 🗓 Burial 2 🔲 0		Removal from S		Place of Disp cemetery, cre	osition (Name of matory or other plac	(e)	Date	20c. Loc	cation - City or To	own, State
Baltimore,	Pag iment tent: jury o		`4 ☐ Donation 5				Loudon	Park	6-	-7-05	Ba	altimore	, Md.
3a	permit Depar Impor any in		21. Signature of Fune	ral Service Licen			2	2. Name and Addre	A4 545-4000			ce, Md.	21202
	707 # 0			adro	W		2	March F.I				orth Ave	
			23a. Part1. Enter the shock, or heart f.	disease, or comp ailure. List only o	dications that ca one cause on ea	used the dea ach line.	th. Do not er	ter the mode of dyin	ng, such as ca	rdiac or respiratory a	arrest,		Approximate Interval Between
	Physician <sup>1</sup>		Immediate Cause (Fir disease or condition	nal	. ACUT	EM	YOCA	RDIAL	INF4	PROTION	1		Onset and Death
	/Medical Examiner		resulting in death)		Due to (	or as a conse					-		
Ŀ.	Zaminer	_	Sequentially list condi	tions,	b								
	ed sit	iner	Sequentially list condi- cause. Enter Underly Cause (Disease or inju-	ing	Director (	or as a doinse	quence ory:						
	icate be executed physician and s the burial-transit	Examin	that initiated events resulting in death) Las		c. Due to (	or as a conse	nence of):						
8760,	be exician	alE			545 15 (	5, 43 4 0011001	4001100 01).						
387	phys the	dical			d								
×	The law requires that the death certificate has been signed by the attending I page 2 should be detached for use as	Physician/Me	IF FEMALE:		23c. If yes, outo	come of prean	ancv					2d Date of delive	
Box	atter for u	ciar	23b. Was decedent pr in the past 12 mg	peths?	1 ☐Live bi	nth 2 ☐ Fetant at time of	al death 3	□Ectopic pregnancy □ Other (specify)	•		2	3d. Date of delive Month	Day Year
o.	the d the ched	iysi	1 ☐ Yes 2 ☑N 9 ☐ Unknown	10	9□ Unkno		300011						
٥.	that hed by deta		Part II. Other significa	int conditions of	ntributing to de	ath but not re	sulting in the	inderlying cause giv	en in Part I.	23e. Did	tobacco us	se contribute to th	ne cause of death?
Sp.	ures sign	d by	ISCHEM	UC CA	PDION	MOPA	THY			10	Yes 2	No 3 □ Prob	pably 4 Dunknown
Records,	w requir been sl should	Completed				-				24a. Was	20	24h Were auto	psy findings available
Re	he lav s has ge 2	щ								auto		prior to cor death?	mpletion of cause of
	ysicien: The is certificate hadirector, page		25 Man gang referred	I to modical						1 Yes	2 No	1 🗆 Yes	2 □ No
$\equiv$	sicie certi	o Be	25. Was case referred examiner?	-	Hospital:	patient 2	] F.D.(Otti-	oth Oth	OF	Death (Check only		T01 10 11	
Division of Vital	Phys r this sral di	$\vdash$	27. Manner of Death	· i	28a. Date o	f Injury	ER/Outpatie	III JUDA	4 🗀 Nursii	ng Home 5 Res 28d Describe			/)
on	ding Ph th. After th funeral	tior	1 Natural 2 Accident	5 Pending investigation	(Montl	n, Day Year)	Injury	Wor	k? Yes 2 □ No		, , , , ,		
ls!	Attending Physicien: r death. ector: After this certifics by the funeral director, I	fica	3 🗌 Suicide	6 Could not be	289. Place	of Injury - At h	ome, farm, st	reet, factory, office		28f. Location	Street and	Number or Rura	il Route Number,
2	after after Direct	Certification:	4  Homicide	determinod	buildin	g, etc. (Speci	fy)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To	wn, State)		
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical C	(Check only 2	Certifying Phy	ілег: On the ba	sis of examina	owledge, dea ation and/or in	h occurred at the tin	ne, date and p pinion, death o	place, and due to the occurred at the time,	cause(s) a	and manner as st place, and due to	ated. the cause(s)
	To the within 2 To the complet	Mec	one) 29b. Signature and title		and mann	ei sidieu.		29c. License		T		signed (Month,	
)	F.M.F.		Loss. Organication and title	1/2/	/2	M		100. 200/15	C111		_	_	
1	X		10	cet C	1	MU		1718	7007		JW	NE, 2,	X002
ĺ	0		30. Name and address	of person who d	ampleted cause	or death (Ite	п 23а) (Туре		PRITU	OF MARY	4 04 11	VATTAN C	AL CENTER
	Sta	te	31. Date filed (Month,	Day, Year)	32. Re	gistrar's Sign	ature	) Ollord		OI MALIC)	UTIV!	VIICUL	- C CONCR
	Registr	_	Ĥ	IN 0 6 20	05	ngistrar's Sign	K A	will					
DH	MH 17 Rev 1/2	001		v v 3	July		7						

ORIGINAL

hysic		Decedent's Name (First, Middle     Ann H. Linki					2. Date of Dea Month May 22	Day Year	3. Time of Death  11:25 PM
/Med Exami		4a. Facility Name (If not institution		•)	4b. City, Town, o	or Location of Death	114/	4c. County of De	
		Shady Grove	Hospital		Rockvi	.11e		Montgom	ery
uneral		5. Social Security Number	6. Sex 7. A 1 ☐ M 2 ☑ F	ge (In yrs. last birthday,	If Under 1 Year   Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	y, Year) 9. Bi	rthplace (State or Foreign
ctor		213-38-0203 Usual Residence of Decedent	TOM ZX	65 Yrs.			Apr 22,		hington DC
any injury or other treumatic event, the Madical Examinar must be notified at once.		10a. State 10b. County	,	10c. City, Town or L	ocation				10d. Inside City Limits
	ō	MD Montgo	omery	Rockvi	ille				1 ☐ Yes 2 🛣 No
	lrec	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	country?
	al	2985 Glenora I	Lane		20	850		USA	
	by Funeral Director	11. Marital Status  1 Never Married 2 Mar	If Yes, Give A	? ]No	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Spean, Mexican, Puerto F Specify:	city Yes or No- Rican, etc.)	Black, Wh	
	q pe	3 Widowed 4 Divorced	Year or Dates  nt's Education		edent's Usual Occup		unk	W	
	Completed	(Specify only highe	st grade completed)	(Give	e kind of work done DO NOT use retire	during most of working	unk unk	16b. Kind of Busines	s/industry
	mo	Elementary/Secondary (0-12)	College (1-4or	5+)				U.S. Gov	ernment
	Be C	17. Father's Name (First, Middle,	Last)			18. Mother's Name	(First, Middle,		
	To B	Malcolm Fra	ncis Hallida	ıy		Erma Lou	ise Stu	uart	
		19a. Informant's Name/Relations F.D. Linkins			-	and Number or Rural Lane Rock		r, City or Town, State, MD 20850	Zip Code)
	1 3	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation '4 ☒ Donation 5 ☐ Other (5		20b. Place of Disposemetery, cre	osition (Name of matory or other pla		ate	20c. Location - City o	r Town, State
0000		21. Signature of Euneral Service Ronal d		cector 2	2. Name and Addre State Ar baltimor	ass of Facility nationy Boar	rd 655 T	W. Baltimo	re Street
ın al		23a. Part1. Enter the disease, o shock, ir heart failure. List Immediate Cause (Final disease or condition resulting in death)	Par Par	ncreatic ca	ter the mode of dying		r respiratory arr	rest,	Approximate Interval Between Onset and Death years
er	L	Sequentially list conditions,	b	s a consequence of):					
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Lissuss or ir jury that initiated events resulting in death) Last	s	s a consequence of):					
	ल	resuming in douting East	d.	s a consequence of):					
	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnanc: □ Other (specify) _	y		23d. Date of de Month	elivery Day Year
	by P	Part II. Other significant condition	ons contributing to death	but not resulting in the t	underlying cause giv	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
	ted						1 🗆 Y	es 2□No 3□F	robably 4 Unknown
	Completed						24a. Was a autops perform	an 24b. Were a prior to death? 2 No 1 \(\) Yes	utopsy findings available completion of cause of s 2 No
	Be	25. Was case referred to medical examiner?				26. Place of Death	(Check only or	10)	
	tion; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendii 2 Accident invest	Hospital:  28a. Date of Inj  (Month, Digition	ury 28b. Time o	of 28c. Injur			ence 6 Other (Spoow injury occurred	ecify)
	Certification;	3 Suicide 6 Could 4 Homicide determ	nined 286. Place of It	njury - At home, farm, st atc. <i>(Specify)</i>	reet, factory, office	2	8f. Location (Si City or Town	treet and Number or F n, State)	Bural Route Number,
	Medical (	29a. Certifier (Check only one)  Certifying 2 Medical	ng Physicien: To the bes Examiner: On the basis and manner s	of examination and/or in	th occurred at the time timestigation, in my o	me, date and place, a opinion, death occurre	nd due to the cand at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
•	Me	29b. Signature and title of certific	r		29c. Licens	se number	2	29d. Date signed (Mon	
					D006	2234		06/01/200	5
ō	1				טטטע	2234			

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		ľ	State State Amend Item 29d p	e of Maryland er Dr.,G84	d / Depa <b>44,06/</b> (	rtment of F	lealth and i Death	Mental Hy	giene Reg. No. 2 (	05	18769
	Physici	an	. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year -	3. Time of Death
	/Medio	cal	Barbara A		r	4h Ciby Tayan	-1	5	4c. County	1005	7,50 M
	Examir	ner	a. Facility Name (If not institution, give street ar	e 170581	tall	R050	r Location of Deat		Bo	Hi r	nore
	Funeral		. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da		9. Birthpl	ace (State or Foreign
	Director		205-34-1742 1 M 25	XF 60	Yrs.	Sionalo Bayo	Tiodio Mini.	Feb6,	1945		PA
	iand ow		0a. State 10b. County	10c. City	, Town or Loc	cation				10	Od. Inside City Limits
	Many	to	MD Harford		Jop	pa					1 ☐ Yes 2 【XNo
	or 28	Direc	0e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?
	hours after death with the Maryland uraf, or Itams 23a or 28a-f show Everalizer must be notified at	Funeral Director	427 Gilmor Road	0	3 40 11	210			USA		- Indian
10	fter de	Fune	Arm 1 □ Never Married 2{X Married 1 □	Decedent Ever in U.S ed Forces? Yes 2X No	5.   13. V	Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	o Rican, etc.)	Bla	ce - America ck, White, e	
33	ral', o	þ	If Ye	es, Give r or Dates:	1	☐ Yes 2 🔼 No	Specify:		Specii	w Whi	te
5-003	72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	eted)	16a. Deced	ent's Usual Occup	eation during most of wo d)	rking	16b. Kind of B		ustry
2121	within sene.	duc	Elementary/Secondary (0-12) Colle	ege (1-4or 5+)		inselor	2)		Fathe		Ashley
ර ල	il Hygid other	a	7. Father's Name (First, Middle, Last)	L.S!	<del></del>		18. Mother's Nar	ne (First, Middle			1101110 y
~	should ba nd Mantal markad o	To B	Clarence Harvey					Smallwo			
Man	and raum		19a. Informant's Name/Relationship (Type, Prin	•			and Number or Ru		-		Code)
,	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mantal Hygiene. It of Health and Mantal Hygiene. If item 27 is marked other then "natural", or Itams 23e or 28e-f show or other traumatic event, it was also because in a standard to or other traumatic event, it was also because in the retification.		Ralph Miller /hush	20b. PI	ace of Dispos	sition (Name of	Road J	Oppa MI	20c. Location		wn, State
O	Pages nent of int: If its		1 ☐8urial 2 ☐ Cremation 3 ☐ Removal 1 ☐ Donation 5 ☐ Other (Specify)	from State Du	emetery, crem ilane y	vatory or other place Valley	5/	31/05	Baltin		
$M_{j}$	permit. Page Department Important: It any injury o		21. Signature of Funeral Service Licensee	0 01	22.	Name and Addre	ss of Facility Co	onnelly	Funera	l Hom	eofEssex
<u> </u>	89 2 8 8		1. Terry o	mell	4	300 N	Mace Ave	e. Balt	imore		1221
			23a. Part1. Enter the disease, or completations shock, or heart failure. List only one cause	^	- 4		ng, such as cardia	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	CUTE K	esfi	Potor	y tou	1416			
	Examiner		■ A <sub>C</sub>	ute P	E						
	p #	iner	Sequentially list conditions, fany, tsaume to immediate cause. Enter Underlying Cause (Disease or injury	ue to (or as a consecu	iarica of):	1	1 0	7			
	be exacuted sician and burial-transit	Examiner	nat initiated events c	e to (or as a consequ	H Con	1 pach	toren	10			
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687	tificate ig phys as the	P	0								
Box	or Attanding Physician: The law requires that the death certifical fler death. Iffer death. Director: After this certificate has been signed by the attending phy in by the funeral director, page 2 should be detached for use as th	Physician/M		es, outcome of pregnar Live birth 2 Petal		Ectopic pregnancy	/			te of deliver	ry Day Year
0.	the at the at	ysici	1 \( \forall \)	Pregnant at time of de Unknown	eath 5	Other (specify)				AIUI I	Day (ea)
<u>α</u>	res that the de igned by the a be detached t		Part II. Other significant conditions contributing	g to death but not resu	ıltıng in the un	derlying cause giv	en in Part I.	23e. Did t	obacco use con	tribute to the	e cause of death?
rds	w requires been sign should be	ed by	Anemia					1 🗆 '	Yes 2 No	3 🗆 Proba	abiy 4 □Unknown
000	e law re has bee ge 2 sho	Completed	Pancy to Penia					24a. Was		Were autop	sy findings available
<u> </u>	Physician: The this certificate his ral director, page	Соп	Bleeding Piath	18515				perfo	rmed?	death?	2 🗆 No
Vita	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?  Hospital:	<i>-</i>		aC aca Oth	05	th (Check only o			
ó	Phys or this oral dii	. To	1 163 21/2140	1 ☑ Inpatient 2 ☐ E  Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of	3□ DOA 28c. Injun	4   Nursing r	lome 5 Resi	dence 6 Oth how injury occur		)
ion	ttanding F death. ctor: After / the funera	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2 ☐ No				
Division of Vital Records,	or Atta ter de irecto n by th	Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At hor building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (. City or Tox	Street and Numi vn, State)	per or Rural	Route Number,
	pital o		29a. Certifier 1 Certifying Physician:	To the heet of my know	uledge death	acquired at the tir	mo date and place	and due to the	souss/s) and m		atod
	To the Hospital or Attandit within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	edicai	(Check only 2 Medical Examiner: On	the basis of examinati I manner stated.	ion and/or inv	estigation, in my o	pinion, death occu	rred at the time,	date and place,	and due to	the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	/_		29c. Licens			29d. Date signe	d (Month, E	Oay, Year) /26/05
				DR MAU	N 00	> Ke	500000		2/2	5/0	5
			30. Name and address of person who completed	a n K I n	23a) (Type, I	Print)	ve Bo	- Itim	SO N	D 2	1237
	Sta	ate		32. Registrar's Signat	ure	-ICVII		1 1 1 1 1	016,1	11 0	
	Regist	rar	JUN 0 6 2005 Blosses	1 15 190							

			1- State of Maryland / Department of Health and M Certificate of Death		giene 005	18770
	20		Decedent's Name (First, Middle, Last)	2. Date of Dea	ath	3. Time of Death
	Physici /Medic		Joseph Jerome Mancini	June	3 2005	10:35p <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	,	4c. County of Dea	
			Charlotte Hall Nursing Home Charlotte Hall		St. Mar	
	Funeral Director		5. Social Security Number 212-16-5195 6. Sex 81 7. Age (In yrs. last birthday) 1 Under 1 Year 1 Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day 7 / 2 / 1	9.80 923 Bal	rthplace (State or Foreign country) Ltimore, MD
	p ,		Usual Residence of Decedent			
	shov	7	10a. State   10b. County   10c. City, Town or Location   MD   St. Mary   Charlotte Hall			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	the M	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	
	death with the Maryland ims 23a or 28a-f show	Dir	29449 Charlotee Hall Rd. 20622		US	ountry?
	death ms 2;	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spr Armed Forces? 14. Was Decedent of Hispanic Origin? (Spr If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Am	erican Indian,
0	or Ite		1 ☐ Never Married 2 ☑ Married   1 ☑ Yes 2 ☐ No ATM V	Rican, etc.)	Black, Wh Specify: Wh	
0000	ours irel',	d by	3 ☐ Widowed 4 ☐ Divorced If Ves, Give Year or Dates:		Specify: **1	
<u>.</u>	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work)	ing	16b. Kind of Business	s/Industry
7	withir ane. than	тč	Elementary/Secondary (0-12)  8th  College (1-4or 5+)  Office Clerk		US Post	Office
7	filled Hygir Sther ent,			(First, Middle,	Maiden Sumame)	
ana	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mantal Hygiene.  If the Marylan and Mantal Hygiene.  If the Marylan are series than "naturel", or Items 23a or 28a-f show or other treumatic event, the Marilcal Examana in until the rediffied at	To Be	Pedro Mancini Joseph:	ine	,	
ary	shou and M s mar umat	_	19a. Informant's Name/Relationship (Type, Print) daughter19b. Mailing Address (Street and Number or Rura	I Route Numbe	r, City or Town, State,	Zip Code)
Ξ.	and 2		Joanne Buck 7975 Hampton Way, 0	Dwings	, MD 207	36
ore	of He		cemetery, crematory or other place)	Date	20c. Location - City o	
Ě	Pag ment tant: jury c		'4 □Donation 5 🗷 Other (Specify) entomb   Oaklawn		Baltimore	
Dallimo	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tre 2002.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jos 263 S. Conkling S	seph N. St. Bal	. Zannino ltimore,	Jr. FH MD 21224
			234. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	or respiratory ar	rest,	Approximate Interval Between
3	nysician	0	Immediate Cause (Final disease or condition a. COION CANCE Y			Onset and Death  UCass
	/Medical Examiner		Due to (or as a consequence of):	525	11	7000
		<u></u>	Sequentially list conditions, if any, feading to immediate b. Due to (ur as a consequence of):	ryopa	a Thy	years
	nsit	nine	Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  c. Pw +a U V		1	years
	execunand nandial-tra	Examiner	that initiated events c. I C I U V V resulting in death) Last Due to (or as a consequence of):			70473
20	icate be executed physician and s the burial-transit	dicail	d.			
00	ntifica ng ph as th	ledi	IS SCHALE.		10	
200	th certendir	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of de	
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	1   Yes 2   No 9   Unknown   4   Pregnant at time of death 5   Other (specify)   9   Unknown		Month	Day Year
Ľ	that the object of the object		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
cords,	uires sign d be	Completed by	Atherosclerotic Cardiovascular disease	1 🗀 Y	es 2⊠No 3⊟P	robably 4 [Unknown
5	w req	iete	Anemia of Chronic Disease	24a. Was a	an 24b. Were a	utopsy findings available
ב	icien: The lav certificate has rector, page 2	ошь	Dementia	autop: perfor	med? prior to death?	completion of cause of
I d	ien: rtifica stor, p	Be C	25. Was case referred to medical 26. Place of Death		/ -	5 2 140
>	Physica this ce al direc	ToE	examiner?  1   Yes 2   No	ne 5 Resid	ence 6 □Other (Spe	ecify)
5	ng Pl		27. Manner of Death 28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28c. Injury at Work?	28d. Describe h	ow injury occurred	
2	tendi leath, tor: A the fu	cati	2 Accident investigation M 1 Yes 2 No			
UNISION	or At after of Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	treet and Number or R n, State)	ural Route Number,
-	spitet		29a. Certifier  124 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the c	ause(s) and manner a	s stated
	To the Hospitel or Attending Physicien: The law within 24 hours after death, within 24 hours after death, To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only one)  2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, d	late and place, and du	e to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier 29c. License number	2	29d. Date signed (Mon.	th, Day, Year)
	. \		Parul Sterri MI D45092		6/4/20	05
1	212		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 HOSpital Read Suite 205 Prince Fred	vicle.	MD 20	0678
A	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 6 2005  32 legistrar's Signature			

MANCINI, JOSEPH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** MARKS MARTIN 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Reconal medical Center Salishun If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) JUNE 15, 1 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 □ F Yrs. Director 212-18-2286 83 MD Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits item 27 is marked other then "neturel", or items 23e or 28e-1 show other treumatic event, the Medical Examinar must be notified at 1 ¥Yes 2 No Director WICOMICO SALISBURY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 182 EMILY DRIVE 21804 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: Specify WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) **PROPRIETOR GROCERY STORE** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be t and Mental I MARKS ISRAEL IDA TEVES 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a. Importent: If item 27 is eny injury or other tret. <u>once</u>. SAMUEL MARKS / BROTHER 819 LONG WHARF ROAD - SALISBURY, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BNAI ISRAEL CEMETERY 06/03/2005 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 devara 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ischemic cordio myo parthe Physician /Medical Due to (or as a consequence of): Examiner Coronary Disease aders Means Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Congestive use as the burial-transit Heart 2 VOS Due to (or as a consequence of): physician certificate be Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. the ģ Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed been obstroctive J's ON disease 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No iabetes 1 ☐ Yes 2 No funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After Hospitel or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29b. Signature and title of certifier. 29d. Date signed (Month, Day, Year) 29c. License number 2

Registrar DHMH 17 Rev 1/2001

State

SEYED

31. Date filed (Months Dev.

DA

Partin Marks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JALALI

0 6 2005

Donbotis

Peninsula Recional Medical Center - Satisbury, Ad 21801

June, 2, 2005

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			ary tarrar	Certifica	ite of	Death		Reg. No.	J 5	187	172
Physician	Decedent's Name (First, Middle, Letter)	est)			1100		2. Dete of De Month	Dev	Year	3. Time of	
/Medical	BLANCHE			MANC	050		JUNE		)5 <sup>Year</sup>	4:35	AM
Examiner	4a Fecility Name (If not institution, git JEWISH CONVALESC					4b. City, Town, or L.	ALTIMOR	,	of Death _TIMOR	) <u>_</u>	
Funeral			e (In yrs. last i		er 1 Year	If Under 24 Hrs.				ace (State o	or Foreign
Director		1□M 2		Yrs. Month	s Days	Hours Min.	8. Date of Bir Month, Da JUNE 2	Ž, 1923	Countr	y) [M	1D
within 72 hours effer death with the Meryland han "netural", or itams 23s or 28s-f show he Medical Examiner must be notified at hempleted by Funeral Director	10a. State 10b. County		10c. City, To	wn or Location					10	d. Inside Ci	ity Limits
28a-f sho	MD BAL	TIMORE		BALTIMOR	E					1 ☐ Yes	2 No
or 28	10e. Street end Number			10f. Z	ip Code			10g. Citizen of V	What Countr	ry?	
ral	13 SHERWOOD AVE					21208				USA	
el; or items 23e or 28e-f s Examiner must be notified I by Funeral Director	11. Maritel Status 1 ☐ Never Married 2 ☐ Married 3 🂢 Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 X Yes 2 ☐ N If Yes, Give Yeer or Dates:		13. Was Dec If Yes, sp 1 ☐ Yes		Hispenic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	- 14. Rac Blac Specify	e - America ck, White, et		<u>:</u>
d other than "naturavent, the Medical Be Completed	15. Decedent's E (Specify only highest gr		16	a. Decedent's Us (Give kind of w	vork done	during most of work	ing	16b. Kind of Bu	usiness/Indu	ustry	
H D	Elementary/Secondary (0-12)	College (1-4or 5		'life. DO NOT		,		NEUC AN	AED TO A	AL ALEL	1CD 6 D
vant, m	17. Father's Name (First, Middle, Last	2		ACCOUNTA	NI E.	XECUTIVE 18. Mother's Nam	e (First Middle	NEWS AN		IN NEW	ISPAPI
	JOSEPH	D.		KANTER		IDA	o (1 1101, 11112010,	Walder Deman	,	RSCHLA	CED
trsumatic a	19a. Informant's Name/Relationship				ss (Street	t and Number or Rur	el Route Numb	er, City or Town,			IGER_
er trsum	PAULA REA / DAU	GHTER		13 SHERW	000	AVENUE - 1	BALTIMO	RF. MD 2	1208		
de la	20a. Method of Disposition		20b. Place	of Disposition (N	ame of		Date	20c. Location -		m, State	
7 0	1 ☐ Burial 2 🂢 Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Speci	Removal from State		TOP SERV		1	6/3/05	TOWS	SON, M	1D	
any injury o	21. Signature of Fareral Service Lice	nsee //				ess of Facility SO					
B B B B B B B B B B B B B B B B B B B	1///Nhal	Kruse	1	8900	REIS	TERSTOWN I	ROAD - I	PIKESVIL	LE, M	iD 212	208
ician dical niner	23a. Part1. Enter the disease, or conshock, or heart failure. List only  Immediate Ceuse (Final disease or condition resulting in death)	e. Rheur	matoid	Arthri	tis	ng, such as cardiac	or respiratory a	rest,	; I	Approximat Interval Bet Onset and I	ween
is sit		b. ————							i		
burial-trensit	Sequentially list conditions, if any, leading to immediate		Due to (or es	e consequence of	):						
<u> </u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c									
Medical	resulting in death) Last	1	Due to (or as a	a consequence of	):				1		
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eteched for us Physician/	Part II. Other significant conditions	contributing to death by	it not regulting	in the underlying	cause di	ven in Part I	23h Did	obacco use cor	ntribute to 1	the cause	of death?
deteched for use	at ii. Other argimeant conditions (	online ding to death bo	of not resulting	in the anderlying	cause gr	venini aiti.		Yes 2 No			
d be det											
shoul							24a. Was perfo	an autopsy rmed?	avail	re eutopsy filable prior to pletion of a seth?	lo
rector, page 2 Be Comp							101	res 20 No	10	Yes 2□	No
director, p	25. Wes case referred to medical					26. Place of Beat	h (Check only o	ne)			
	exeminer? 1 ☐ Yes 2 ☐ No	Hospitel: 1 Inpatie	nt 2 ER/C	Outpatient 3	DOA Ot	her: 4 Nursing Ho	me 5 Resid	dence 6 Oth	er (Specify)	)	
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, De)	Year) 28b	. Time of Injury	28c. Inju Wo	ry at rk?	28d. Describe I	now injury occurr	ed		
the fu	2 Accident investigation			М		Yes 2 No					
led in by the funere Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Inju- building, etc	ury - At home, c. (Specify)	farm, street, facto	ory, office		28f. Location (S City or Tox	Street and Numb vn, State)	er or Rural i	Route Num	ber,
completely filled in by		nysicien: To the best of niner: On the basis of and manner ste	examination e								i)
To the Funeral Director: A completely filled in by the filled in Medical Certification	29b. Signeture and title of certifier			2	9c. Licens	se number		29d. Date signed	d (Month, D	ay, Year)	
1/	> nestajupahn u	0 :			D	0057465		VINIE	3,200	K	
	30. Neme end eddress of person who	completed cause of de	eeth (Item 23e	) (Type, Print)		se number 005746 <sup>5</sup> Rejstersten		2/	-,000	<i>C</i> 2	
	N.S. Rajapakse	MD 25	Main St	, Suite 20	01	Reisterston	IN, MD	21136	7		
State	31. Dete filed (Month Day Year)	32 Kegistre	er's Signature	Mark.	-						

Registrar

DHMH 16 Rev 6/95

			Health and Mental Hy  f Death	•
Physician	1. Decedent's Name (First, Middle, Last)		2. Date of D Month MAY	Day Your
/Medical	Glenn Owens	Ab Ciby Tours		22, 2005 5:42A. M
Examiner	4a. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER	CHEVE		PRINCE GEORGES
Funeral Director	5. Social Security Number  158-40-6803  Usual Residence of Decedent	Months Day	s Hours Min (Month D	9. BNighton January (2007) 19, 1961 10, 1960 11, 1960 12, 1961 13, 1960 14, 1961 15, 1960 15, 1960 16,
ehow		City, Town or Location		10d. Inside City Limits  ▼ Y□ Yes 2 □ No
Sittle death with the Ma ritems 23s or 28e-1 siner must be notified funeral Director	Maryland Prince George Cap  10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?
ath with 123a o	1609 Pacific Avenue		20748	United States
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If Item 27 is marked other than "natural", or items 23s or 28e-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.  To Be Completed by Funeral Director	11. Marital Status  1 □ Never Married 2X Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in the Armed Forces?  1 X Yes 2 □ No If Yes, Give Year or Dates: 196	1 ☐ Yes 2 ₩ N	f Hispanic Origin? (Specify Yes or N uban, Mexican, Puerto Rican, etc.) o Specify:	o- 14. Race - American Indian, Black, White, etc.  Specify: Black
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exami To Be Completed by F	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occ (Give kind of work don life. DO NOT use retii	upation e during most of working red)	16b. Kind of Business/Industry
Ned w kygier the her the cor	Tenth	Painter	18. Mother's Name (First, Middle	Construction
Vland witd be fill Mental H arked oth artic even	17. Father's Name (First, Middle, Last)  Robert Owens		Rosalie Banks	e, maideir Surriame)
Mary and 2 shou alth and N 27 is ma	19a. Informant's Name/Relationship (Type, Print) John Owens/Brother		et and Number or Rural Route Number Silver Spring,	
Ore,		Place of Disposition (Name of cemetery, crematory or other page 2)		20c. Location - City or Town, State
Baltimore, bermit. Pages 1 ar Department of Hea mportant: If Item any injury or othe anges.	`4 □ Donation 5 □ Other (Specify) Res			Clinton, Maryland Mason Funeral Home
Bal permi Depa Impo any is	In In Just Moull			shington DC 20020
Physician	23a. Part 1. Enter the disease, or complications that caused the deashock, or heart failure. List only one cause on each line.     Immediate Cause (Final	-		arrest, Approximate Interval Between Onset and Death
/Medical Examiner	disease or condition resulting in death)  a  Due to (or as a conse	o Injectie	2	
- L	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Classes of Injury	equence of):		
60, be executed sician and burial-transit	Cause Disease of mining that initiated events c. Due to (or as a conservation of the c	action co of).		
76( sysicial ne bur	d			
ords, P.O. Box 68 requires that the death certificat near signed by the attending phy hould be detached for use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregrant 1 ☐ Live birth 2 ☐ Ferendament at time of 9 ☐ Unknown	tal death 3 Ectopic pregnan		23d. Date of delivery Month Day Year
cords, P.( w requires that it been signed by should be detac	Part II. Other significant conditions contributing to death but not re	sulting in the underlying cause o		tobacco use contribute to the cause of death?  Yes 2 XNo 3 Probably 4 Unknown
I Rec The law ate has b page 2 s				s an ppsy are autopsy findings available prior to completion of cause of death? 2 □ No 1 No 2 No 2 No
Vital Riclan: The certificate rector, pag	25. Was case referred to medical examiner?		26. Place of Death (Check only	
# 호 플립 F	1 X Yes 2 No Hospital: 1 ☐ Inpatient 2 2 27. Manner of Death 28a. Date of Injury	ER/Outpatient 3 DOA 28b. Time of 28c. Inj	Other: 4 Nursing Home 5 Res	sidence 6 Other (Specify)
E grander lo	1 Natural 5 Pending (Mnth, Day Year)	Injury W	ork? □Yes 2 No Driv	ver in a motorvehicle
Division of teal or attending Phy rs at for attending Phy rs at for death.  al Director: Atter this led in by the funeral decretification; To Certification; To	2 Could not be	home, farm, street, factory, offic	e 28f. Location	(Street and Number or Rural Route symber,
Division is a state or an all Dirich ed in I	Romand Ro	adway	5 mall	own, State) 3B Rt. 3010 No.
Hosp 4 hou Funer iely fill	29a. Certifier (Check only and)  1 Certifying Physician: To the best of my kn (Check only and indirect stated).	nowledge, death occurred at the nation and/or investigation, in my	time, date and place, and due to the y opinion, death occurred at the time	e cause(s) and manner as stated. , date and place, and due to the cause(s)
To the within 2 To the complet	29b. Signature and title of certifier		nse number	29d. Date signed (Month, Day, Year)
2	I carol Hallan n	4	CME	MAY 23, 2005
3	30. Name and address of person who completed cause of death (It	111 Pe	nn Street Balti	more, Maryland 21201
State Registrar	31. Date filed (Month, Day, Year)  JUN 0 6 2005	nature		

		1	For State Registrar		aryland / Depa	artment of F		Re	g. No.	18774
	Physicia		Decedent's Name (First, Middle, La	st)		Dorre		2. Date of Death Month	Day Year	MAC THE
	/Medic	al -	Moses  4a. Facility Name (If not institution, given	on etmat and number)		Perry	r Location of Death	JUNE	2 2005 4c. County of De	
	Examin	er	Union Memorial				altimore		NA	
	Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,		irthplace (State or Foreign Country)
	Director	-	238-20-4602 Usual Residence of Decedent	M Z I	83 Yrs.			10-28	-21	Ga.
	yland how		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Ba-f s	Director	Md. NA		Bal	timore				1 X Yes 2 □ No
	with the	Dire	10e. Street and Number 5430 Park Heigh	te Avo A	nt 411	10f. Zip Code 212	15	10	g. Citizen of What ( USA	Country?
	after death with the Maryland or Itams 23a or 28a-f show ortrer must be rigitied at	eral	11. Marital Status	12. Was Decedent 8	<del>-</del>	Was Decedent of H		pecify Yes or No-	14. Race - An	nerican Indian,
9	ba filed within 72 hours after death with the Marylan stal thygiene. ed other then "neturel; or itams 23a or 28a-f show event, it a Medical Examinat mast be notified at	by Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 1	40	1 ☐ Yes 2X No		o Rican, etc.)	Black, Wt	Black
21215-0036	72 hours neturel',	d be	3X Widowed 4 □ Divorced  15. Decedent's E	Year or Dates:		dent's Usual Occur		1	6b. Kind of Busines	
75	nin 72 un "ne'	Completed	(Specify only highest gi		(Give	kind of work done DO NOT use retire	during most of wor d)	rking	55. 11.114 01 5501110	
	a filed within al Hygiene. I other then " vent, Ire Mer	Com	8th grade			rehousem				Lithograph Co.
Maryland	t ba fill ntal H ed oth	Be	17. Father's Name (First, Middle, Las Albert	1)	Perry		18. Mother's Nan	ne (First, Middle, M	aiden Sumame) Bye:	rs
ary Z	12 should ba and Mental I is marked or reumatic eve	은	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail		and Number or Ru	ıral Route Number,	City or Town, State	Zip Code)
Ž,	and 2 alth a 27 is er treu		Fred Perry	Son			HINGTON :		IMORE, MD	
Baltimore,	ges 1 of He if item or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Removal from State	1	matory or other pla			Oc. Location - City	
III III	it. Par intmen intent: njury	1	<ul> <li>4 ∑Donation 5 ☐ Other (Spec</li> <li>21. Signature of Funeral Service Lice</li> </ul>			Carmel Cer 2. Name and Addre		No. of Contrast of	Dundalk, more, Md.	Ma. 21202
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked any injury or other treumatic es <u>once.</u>		Jenes 17	6		March F.			. North	
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or cor shock, or heart failure. List ont Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	aDue to (or as	a consequence of):		ng, such as cardiad	c or respiratory arre	st,	Approximate Interval Between Onset and Death  Aug.
68760,	ificate be executad g physician and as the burial-transit	edical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Usaase or rijury that initialed events resulting in death) Last	,	a co equence o :	Island 26	Chanc O.	sum P	sluence, Di	xxx Xdemi
.O. Box	that the death certificate ed by the attending phys detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of o Month	lelivery Day Year
Ω.	w requires that the been signed by th should be detache	by	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause gi	ven in Part I.			to the cause of death?  Probably 4 Unknown
Vital Records,	The taw ate has b page 2 s	Completed			<u> </u>			24a. Was ar autopsy perform 1 Yes 2	24b. Were prior t death	
/ita	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	Hospital:		Ott		ath (Check only one	1	
of	ling Phys 1. After this tuneral di	tion; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigate investigate	28a. Date of Inju (Month, Da	-	of 28c. Inju		fome 5 ☐ Resider 28d. Describe ho	nce 6 Other (S) w injury occurred	pecify)
Division	Atten ar dea ector by the	Certification:	2 Accident Investigati 3 Suicide 6 Could not determine	be 28e. Place of Inj	ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (Str City or Town		Rural Route Number,
	To the Hospitel or within 24 hours after To the Funerel Discompletely filled in	edical	29a. Certifier 1 Certifying F (Check only one) 1 Medical Ex	Physician: To the best aminer: On the basis o and manner st	f examination and/or i	ith occurred at the to nvestigation, in my	me, date and place opinion, death occu	urred at the time, da	ite and place, and d	ue to the cause(s)
)	To the within 2 To the complete	Me	29b. Signature and title of certifier	L-m.o.		29c. Licen	se number 243 8946		Od. Date signed (Mo	
	2		30. Name and addr ss of person wh	completed cause of c	death (Item 23a) (Type	e, Print)	7	20.00	71715/	
1 2	St. Regist	ate rar	31. Date filed (Month, Day, Year)  JUN 0 6	2005 37 Registr	COLE, UN NETZ	sory premary	MALTIME	ie, MD	CILIY	
	1109100	S 12 18	<b>4 4 1 1 1</b>	1000						

			State of Maryland / D	ера		ealth a		ental Hy		_	18775
	Physici	an	Decedent's Name (First, Middle, Last)		imodio or a	Joann		2. Date of Dea Month	ath Day		3. Time of Death
	/Medic	al	Myrtle Irene Priebe  4a. Facility Name (If not institution, give street and number)	-	4b. City, Town, or	Logation	f Dooth	June	3	2005 County of Death	2:20 P M
	Examin	er	Genesis Eldercare			oklyr		·k	40.		Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	iday)	If Under 1 Year	If Under 2	24 Hrs	9 Data of Birt	h Vear		
	Director		215-24-9130 1□ M 2X F 103 Y	rs.	Months Days	Hours	MIN.	May 20	190	02 Mary	lace (State or Foreign try) Land
	/land		10a. State 10b. County 10c. City, Town	or Lo	cation					1	0d. Inside City Limits
	e-fst	ctor	MD Anne Arundel	В	rooklyn P	ark					1 ☐ Yes 2 No
	vith the	Funeral Director	10e. Street and Number 613 Hammonds Lane		10f. Zip Code	1225		-	-	zen of What Cour	•
	eath v	erai	11. Marital Status 12. Was Decedent Ever in U.S.	13 \			nin? (Spe			ed State	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28e-f show any Injury or other treumatic event, the Medical Exertination in the netition at once.	by	Amed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba I□ Yes 2 No		, Puerto I	Rican, etc.)		Black, White,	
2-0	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	Deced Give	ient's Usual Occupa kind of work done of OO NOT use retired	ation during most	of workii	ng	16b. Kir	nd of Business/Inc	dustry
121	within ne. han	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		00 NOT use retired usekeepin				T	anitoria	1
9	filed v Hygie sther i		17. Father's Name (First, Middle, Last)	110	usekeepin		r's Name	(First, Middle,			L
Maryland 21215-0036	uld be dental rrked c	To Be	Llyod Parker			Cath	erin	e Brown	1		
/Jan	and had l			_	ng Address (Street a						Code)
رة أ	1 and Health tern 27				Clyde Ave sition (Name of natory or other place			downe,		ZIZZ/ cation - City or To	wn, State
I O	Pages lent of nt: If it	1	Langual Selecteuration 2 Perinosa nom 2/are		natory or other plac rematory,		6-6	-2005	Bal	Ltimore,	MD
Baltimore,	permit. Departm Importe any Inju	(	2) Signature of Funeral Se	7 22	Name and Addres	s of Facility	y Amb	rose Fu	inera	al Home,	Inc.
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	4							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition ARTGNOSCE								Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence o	f):					210	EASE	
		er	Sequentially list conditions, if any, leading to immediate b.	Ŋ.		_	_				
/	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
760,	icate be executed physician and s the burial-transit	cai Ex	resulting in death) Last Due to (or as a consequence or	f):							
687	ficate physis the		d								
Вох	leath certificat attending phy I for use as the	M/ut	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3	Ectopic pregnancy				2	3d. Date of delive	,
P.O. B	t the c by the achec	Physician/Med	in the past 12 months?  1  Yes 2 No 9 Unknown  1 Unknown		Other (specify)					Month	Day Year
	res tha igned be det	by	Part II. Other significant conditions contributing to death but not resulting in	the ur	nderlying cause give	en in Part I.					ne cause of death?
ord	w require been si should I	eted	DEMENTIA							I	ably 4 Tunknown
Vital Records,	The law cate has be page 2 s	Completed								24b. Were auto prior to con death? 1 \( \text{Yes}	psy findings available inpletion of cause of
Vita	sicien certifi rector	Be	25. Was case referred to medical examiner?  Hospital: Hospital:		Othe			(Check only o			
ot	Phys or this oral di	: To	27. Manner of Death 28a. Date of Injury 28b. Ti	me of	28c. Injury	at		ne 5 🗌 Resid 28d. Describe h		Other (Specify	")
ion	inding ath. r: Afte	atior	1 ☑ Matural 5 ☐ Pending (Month, Day Year) In 2 ☐ Accident investigation	ury	M 1 🗆	<br Yes 2 □ i	Vo				
Division	To the Hospitel or Attending Physicien: The I within 24 hours after death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fan building, etc. (Specify)	n, str	eet, factory, office		2	28f. Location (S City or Tow	Street and In, State)	d Number or Rura	l Route Number,
	ne Hospit 24 hour ne Funere	edical (	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, 2 Medicel Exeminer: On the basis of examination and and manner stated.	death /or inv	occurred at the time restigation, in my op	ne, date and pinion, deat	d place, a	and due to the dead at the time,	cause(s) date and	and manner as si place, and due to	ated. the cause(s)
	To the within To the comp	Š	29b. Signature and title of certifier		29c. License		,			e signed (Month,	
•			Murder MD							E 6, .	
_	1					Au	NO	2 57	6	ALTIN	nort 21225
	Sta Registr		31. Date filed (Month, Day, Yeer)  JUN 0 6 2005  32 Registrar's Signature	1	. W						
DH	MH 17 Rev 1/20		EVOS JOSEPH AS	100					-		

ORIGINAL

Thomas Pollard 05-3754 AKG

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State	State of Maryland / Depa	artment of Health and I <i>rtificate of Death</i>	•	200	5 10776
			Registrar  1. Decedent's Name (First, Middle, Last		Tillicate of Death	2. Date of Dea	Reg. No. U	3. Time of Death
	Physicia /Medic		Thomas Pollard			June 1	, 2005	5:00 A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give North Arundel Host		4b. City, Town, or Location of Deatl GLEN BURNIE	1	Anne A	
	Funeral Director		5. Social Security Number 6. Se		If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth Month, Day	h 0	Birthplace (State or Foreign Country) laryland
	D		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	Ocation			10d. Inside City Limits
	Maryla -f sho	to	Maryland Anne A					1 ☐ Yes 2 ☐ No
	th the	lrec	10e. Street and Number		10f. Zip Code		10g. Citizen of Wha	at Country?
	ath wi	rai	1480 Westcliff		21122	3	Jnited S	
36	d within 72 hours after death with the Maryland piene. rr than "netural", or Items 23e or 28e-f show the Medical Examana in must be motified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☐ No Specify:	pecify Yes or No- o Rican, etc.)		American Indian, White, etc.  White
21215-0036	72 hou netura	ted	15. Decedent's Edu (Specify only highest grad	ucation 16a, Dece	dent's Usual Occupation kind of work done during most of work	king	16b. Kind of Busin	
121		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	9		
	E A E		17. Father's Name (First, Middle, Last)	3 Syst	ems Analyst  18. Mother's Nar	ne (First, Middle,	Compute Maiden Sumame)	rs
/lan	T = 0 0	To Be	Earl J. Pollard		Dolore	s C. Ki	mmey	
Maryland	and and sm		19a. Informant's Name/Relationship (T)	· · · · ·	ng Address (Street and Number or Ru			
	as 1 and 2 of Health item 27 I		20a. Method of Disposition	lard - Wife 1480	osition (Name of	ve Pasa	adena, M 20c. Location - Cit	
mo	Pages nent of nnt: If i	-	1 ☐ Burial 2 ☐ Cremation 3 ☐ S  1 ☐ Donation 5 ☐ Other (Specify,	Hemoval from State	matory or other place) Park 06/	06/05 F	altimor	e, Maryland
Baltimore,	permit. Pages 'Department of H Importent: If ite any injury or ot once.		21. Signature of Funeral Service Licens	Ubbu CFSP D	2. Name and Address of Facility avid J. Weber	Funeral	Homes	P.A. re, MD 21229
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death. Do not enone cause on each line.				Approximate Interval Between Onset and Death
<b>)</b>	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Intracevelma	al He mont	age		Oriset and Death
ŀ	Examiner			Due to (or as a consequence of):  Heapon Hucive	al He mont	c Car	diovascila	ay I
	D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):	Disease	0 0000	7 (0 10 - 30.40	
	icate be executed physician and s the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c				
68760,	te be e ysiciar ne burit	dical		d				
		0	IF FEMALE:	00- 11				
Вох	death certifi e attending i id for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of death 5[	Ectopic pregnancy Other (specify)		23d. Date o Month	f delivery Day Year
P.0	the che	Phys	9 🗆 Unknown	9⊡ Unknown				
	law requires that as been signed b 2 should be deta	þ	Part II. Other significant conditions co	ontributing to death but not resulting in the u	nderlying cause given in Part I.			ite to the cause of death?  Probably 4 Dunknown
Records	e law re has bee	Completed				24a. Was	an 24b. Wer	re autopsy findings available r to completion of cause of
a B	Th ate pag					1 XYes	méd? dea 2 □ No 1 X	th? Yes 2 No
Vital	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 🂢 ER/Outpatier	Other	th (Check only o	<i>ne)</i> dence 6 □Other (	(Spanis)
on of	ling I. After Tune	-	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury			now injury occurred	<i>эрвспу)</i>
Division	or Attending after death. Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (S City or Tow	Street and Number o vn, State)	or Rural Route Number,
	To the Hospitel or Atter within 24 hours after de To the Funerel Directo completely filled in by the	ledical C		/sician: To the best of my knowledge, deat iner: On the basis of examination and/or in and manner stated.				
	To the To the To the Compl	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (A	Aonth, Day, Year)
	7		· Caroen	tallan wa	OCME		JUNE 1,200	05
1	D			completed cause of death (Item 23a) (Type.	Print) 111 Penn Street	Baltim	ore. Marv	71and 21201
	. Sta	te	CAROL H. ALLAN MD 31. Date filed (Month, Day, Year)	32. Digistrar's Signature				
	Registr	ar	JUN 0 6 20	105 Alexan St A	9845L			

DHMH 17 Rev 1/2001

		4	For State Registrar	State of Mar		artment of		and Mer		ene g. №2 0 0 5	10777
			Decedent's Name (First, Middle, Last)	<del></del>					Date of Death Month	The last to the la	3. Time of Death
	Physicia /Medic	al	R <u>ita Petza</u>						June 2,	2005	5:45 A M
	Examin	er	4a. Facility Name (If not institution, give sti Oak Crest Village	reet and number)		4b. City, Town Baltin	•	of Death		4c. County of Dea Baltimor	
	Funeval		5. Social Security Number 6. Sex	7. Age (	(In yrs. last birthday)	If Under 1 Yea	ar If Under	24 Hrs. 8.	Date of Birth (Month, Day,		thplece (State or Foreign buntry)
	Funeral Director			M 2⊠F	86 Yrs.	Months Day	s Hours	Min. 1	Month, Day, /13/19]	19 Ma	ryland
	put		Usual Residence of Decedent  10a. State 10b. County		IDc. City, Town or L	ocation					10d. Inside City Limits
	Maryla f sho	Ď	MD Baltimo	re	Baltin	ore					1 ☐ Yes 2 ⊋ No
	r 28a	Director	10e. Street and Number			10f. Zip Code	•		10	g. Citizen of What Co	ountry?
	23e o 23e o Ust be	alD	8820 Walther Blvd				1234			U.S.A.	
	er dez Itema	Funeral		2. Was Decedent Ev Armed Forces?		Was Decedent of If Yes, specify Co	f Hispanic Ori uban, Mexican	gin? (Specify n, Puerto Rica	y Yes or No- an, etc.)	14. Race - Ame Black, Whit	
336	ars aft	by F	12 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:		1☐ Yes 2 N	lo Specify:			Specify: Wh	ite
2-0	u within 72 hours after death with the Maryland jien. jien. ithe It b.M. Jical Examiner must be neithed at	sted	15. Decedent's Educa (Specify only highest grade		(Give	dent's Usual Occ	ne durina mos	t of working	1	6b. Kind of Business	/Industry
2		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use reti	ired)	_		74m. af D.	1 # 4
d 2	e filed within al Hygiene. I other than ' vant, I're M.	e Co	17. Father's Name (First, Middle, Last)	4		Teacher	18. Mothe	er's Name (F		City of Ba Maiden Sumame)	ltimore
an	lid be lental ked o	To B	Edward Petza				Agr	nes Bei	nedict		
Maryland 21215-0036	ges 1 and 2 should be filled it of Health and Mental Hyg If itam 27 Ia marked othe or other traumatic avant,		19a. Informant's Name/Relationship (Type	e, Print)		3				City or Town, State,	
, 0	ss 1 and 2 of Health of Health itam 27 I		Janet Lamenzo  20a. Method of Disposition		4 M 20b. Place of Disp			re Bloo Date	-	CT. 0600	
Jor	Pages I nent of H ant: If its ury or ot		1 ⊠ Buriai 2 ☐ Cremation 3 ☐ Re	moval from State	Holy Red	matory or other p	olace)	6/4/0	187	Baltimore,	
Baltimore,	permit. Page Department of Importent: If any injury or once.	1	'4 □ Donation 5 □ Other (Specify)  21. Signature of Euneral Service Licenses				dress of Facilit				1 Home Inc.
ä	Per language and per la		1 2/1/							Maryland	21206
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the cause on each line	he death. Do not en	ter the mode of o	tying, such as	cardiac or re	espiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		Deme	nta					
۱	Examiner		- 1	Due to (or as a	consequence of):						
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):						
d	ate be executed hysician and the burial-transit	Examine	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a	consequence of):						
8760,	be exician a			Due to (or as a	consequence ory.						
687	the the	edical	a.								
Вох	death certific e attending p id for use as t	an/M	23b. was decedent pregnant	c. If yes, outcome of		⊒Ectopic pregna	ncy			23d. Date of de Month	livery Day Year
	0 0 0	Physician/Me	in the past 12 mg/hths? 1 □ Yes 2 ☑No 9 □ Unknown	4□Pregnant at ti 9□Unknown		Other (specify)				Month	Day
P.0	the Bell	/ Ph)	Part II. Other significant conditions cont	ributing to death but	not resulting in the	anderlying cause	given in Part I		23e. Did tob	acco use contribute t	o the cause of death?
Vital Records,	quires n sign ald be	ed by							1 ☐ Ye	s 200 No 3□P	robably 4 Unknown
900	e law require has been siy ye 2 should b	Completed							24a. Was an	24b. Were a	utopsy findings available completion of cause of
I R		Com							perform	ned? death? ☐No 1 ☐ Yes	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:			Othor		Check only one		
of		1: To	1 Yes 2 No	1 ☐ Inpatient 28a. Date of Injury (Month, Day		nt 3 DOA	njury at Vork?			nce 6 ①Other (Spe w injury occurred	ecity)
ion	Attending P death. ctor: After t y the funera	atio	1 Matural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury		Yes 2	No			
Division	or Attendated death after death	Certification:	3 Suicide 4 Homicide  6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, s (Specify)	treet, factory, office	сө	28f.	. Location (Str City or Town,	eet and Number or R , State)	ural Route Number,
	spitel ours a naral L		29a. Certifier 1 Certifying Physi	cian: To the best of	my knowledge, dea	th occurred at the	time, date ar	nd place, and	due to the ca	use(s) and manner a	s stated.
	To the Hospitel or Attending within 24 hours after death.  To the Funaral Director: Attencompletely filled in by the fune	Medical	(Check only 2 Madical Examin one)	er: On the basis of e and manner state	examination and/or in	nvestigation, in m	y opinion, dea	ath occurred	at the time, da	ite and place, and du	e to the cause(s)
	With To t	Σ	29b. Signature and title of certifier	MD		29c. Lice	35/8	25	29	od. Date signed (Mon	th, Day-Year)
	1		30 N/S 20 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	noloted earlies of de-	oth (Itom 00a) (TA	D. Briat)	100		1	01210	
	5		30. Name and addless of person who cor	8800	ath (Item 23a) (Type	Bh	1d,	Henk	wille	, MD.	21234
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) / JUN 0 6 2005	32. Registrar	S. Seco	K					

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KAR B.

			For State Registrar	State of Maryla		epartment o Pertificate o		•	giene Rag. No. 20	05	18778
	Physici	an	1. Decedent's Name (First, Middle, Last)		-	-		2. Date of De Month	_	Year	. Time of Death
	/Medic	al	Anthony  4a. Facility Name (If not institution, give	B.	Ree	efe	n, or Location of	May	31 , 2		9:18 A M
	Examin	er	Shady Grove Adven		a1		kville	or Death		gomery	
	Funeral Director		Social Security Number 6. Seg.		rrs. last birtho	Months Da		Min (Month, Da	rth		(State or Foreign
	pu .		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town o	or Location				10d. la	Inside City Limits
	Maryla f sho	ō	Maryland Montgome		Damas						1 ☐ Yes 2 ☒ No
	r 28a	irec	10e. Street and Number			10f. Zip Coo	le		10g. Citizen of V	What Country?	
	23a c	alD	10401 Bethesda Chu	rch Road, Ap	ot B	2087	2		United		
336	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28a-f show any njury or other treumatic event, the Medical Ever's a strungthe notified at ance.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2XXXIII If Yes, Give Year or Dates:	n U.S.	13. Was Decedent If Yes, specify €	Cuban, Mexicar	gin? (Specify Yes or No n, Puerto Rican, etc.)	Blac	e-American Ir ck, White, etc. /: White	
21215-0036	thin 72 horen	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(0	ecedent's Usual Oc Give kind of work do fe. DO NOT use re	one during mos otired)	t of working	16b. Kind of Bu		
2	led witygien her th	Col	12 17. Father's Name (First, Middle, Last)			Man	ager	er's Name (First, Middle		Service	9
and	d be fi	To Be	Frank Reefe					arie Brackl		10)	
Maryland	id 2 shoul Ith and Me 27 Is mark treumati	ř	19a. Informant's Name/Relationship (Ty Scott Reefe - Son	рө, Print)				er or Rural Route Numb			de) 21701
Baltimore,	ages 1 ar ant of Hea it: If item 3		20a. Method of Disposition 1   ↑ Burial 2 □ Cremation 3 □ F  ↑ 4 □ Donation 5 □ Other (Specify)	temoval from State	cemetery,	hisposition (Name of crematory or other 1s Cemete	place)	Date June 4, 200	20c. Location -	-	
Baltir	permit. P Departme Importen any njur		21. Signature of Funeral Service Licens		/	01 in L.	dress of Facility	orth Funera	1 Home	20872	,,
	Physician		23a. Part1. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition	ications that caused the cause on each line.		t enter the mode of				App Inte Ons	proximate erval Between set and Death
	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of		uru fr	tery Disco	Şe.	Ye	50.2
8760,	death certificate be executed e attending physician and of for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conduct.  Due to (or as a conduct.							
O. Box 68	ne death certiff the attending thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ I 4 □ Pregnant at time 9 □ Unknown	Fetal death	3 □Ectopic pregn 5 □ Other (specif				te of delivery Inth Day	/ Year
ds, P.	juires that the signed by ald be detact	by	Part II. Other significent conditions co	2	resulting in t	Λ		. 23e. Did	tobacco use cont Yes 2 □ No		ause of death?
Vital Records,	The law requires ate has been sign page 2 should be	Completed						24a. Was auto perf 1 \( \text{Yes}	ppsy ormed?	Were autopsy f prior to comple death? 1 □ Yes 2 □	findings available ation of cause of
ital	ysicien: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?					of Death (Check only			
of	Phys r this ral dii	ည	1 Yes 2 No  27. Manne of Death  Natural 5 Pending	1 Inpatient 28a. Date of Injury (Month, Day Yea	28b. Tin	ury	Cther: 4 Nu Injury at Work? 1 Yes 2		idence 6 Oth		
Division	or Attenditter death	Certification:	Ž Accident investigation  3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp	At home, farm			28f. Location	(Street and Numb wn, State)	per or Rural Ro	ute Number,
	Hospital 24 hours Funeral tely tilled	ledical C		sician: To the best of my nar: On the basis of exar and manner stated.							
	To the within 2 To the comple	Me	29b. Signature and title of certifier	7	my	29c. Li	cense number		29d. Date signe	d (Month, Day,	Year)
			Housta	Newde		800	5802	5	MAY 3	SI 200	05
	10		30. Name and address of person who c				_				
	Sta	ito	Jonathan Wenk MD  31. Date filed (Month, Day, Year)	9901 Medic  32 Registrar's S		ter Drive	e, Rock	ville, Mary	land 208	850	
	Regist		JUN 0 6 2005	Beaut &	Space	E.					

amend item#105, pertrh, G744, 6/6/05 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** Robinson 2005 5:21 A Gilbert MAY 18 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CHARLES LAPLATA CIVISTA MEDICAL CENTER 8. Date of Birth 1932 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1**≦** M 2□ F 14 Director December Maryland 579-40-5379 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State St. Mary's 28a-f show traumatic avant, the Madical Examiner must be notified at 1X Yes 2 □ No Funeral Director MD Charlotte Hall 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 38455 Pleasant View Drive 20622 USA or Itams 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. All Myes 2 □ No Airforce
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify þ Specify. 3 Widowed 4 Divorced Black. "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7/ h and Mental Hygiene." 7 is markad othar than "n College (1-4or 5+) Elementary/Secondary (0-12) Computer Operator Government l yr 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be ပ John Robinson Bernice Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) itam 27 Katie Robinson/Wife 38455 Pleasant View Drive Charlotte Hall, Nd 20622 othar Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department of Important: If any Injury or once. Alington Veteran's 5/26/05 \* 4 ☐ Donation \_ 6 ☐ Other (Specify) Arlington, Virginia 22. Name and Address of Facility 21 Ignature of Funeral Service I cen-J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Beat 23a. Part 1. Enter the disease or co Immediate Cause (Final disease or condition resulting in death) KENAL Priysician /Medical Examiner TUBULA CUTE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed SiS the burial-trans Due to (or as a consequence of) Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day ō in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ MELLITUS 1 Yes 2 No 3 Probably 4 Unknown Completed TENJION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 ☐ Yes 2 ☐ No 2 NO 25. Was case referred to medical examiner? the funeral director. Be 26. Place of Death (Check only one) Hospital: 1 patient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 PNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 THomicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical within 2 To tha 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2005 de D-44436 rson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of 10 <u>ASHVINKUMAR</u> PATEL MD 102 PAUL MELLON CT. STE 102 WALDORF, MD 20602 31. Date filed (Month, Day, Year)
MAY 2 4 2005 32. Registrar's Signature State Registrar

			1 For State	State of Maryla	nd / Depa	artmen		lth and M	lental Hy	giene			7 Q A
	12		Registrar  1. Decedent's Name (First, Middle, La	ist)		imout	0 0, 00	-CU1	2. Date of Dea	Reg. No.	000	3. Time of	Death
	Physici		Patricia A. Ruby	•					May 27,	2005	Year	3:05	
	/Medio Examir		4a. Facility Name (If not institution, given		<del></del>	4b. City,	Town, or Loc	ation of Death	IMY ZI		ounty of Death	1	
	LAdiiii	101	St. Martin;s Hom			Cat	onsvil	.le			timore		
	Funeral		5. Social Security Number 6. 3	Sex 7. Age (In yrs	s. last birthday)	If Under Months		Under 24 Hrs. ours Min.	8. Date of Birt (Month, Da	h V Year)	9. Birthp	lace (State or	r Foreign
	Director		414-00-2447	<sup>1□ M</sup> <sup>2</sup> <b>X</b> F 57	Yrs.	MORES	Days	Outs IVIII.	Jan. 15	194	8 Mary	zland	
	pu k		Usual Residence of Decedent  10a. State 10b. County	100.0	City, Town or Lo	ration					1	0d. Inside Cit	v Limite
	sho	ō.				oution					[ '	1 🗆 Yes	
	28a-f	ect	Md. Prince	George B	owie	10f. Zip	Code			10a Citizar	n of What Coun		
	with Sa or	Funeral Director	2404 Kinderbrook	Lano			20715				USA	My I	
	ns 23	era	11. Marital Status	12. Was Decedent Ever in	U.S. 13. 1			nic Origin? (Spe lexican, Puerto	ecify Yes or No-		Race - Americ	an Indian,	
(C)	r Itar	핕	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X No					Rican, etc.)		Black, White,		
93	ral', o	i by	3 ☐ Widowed 4 🔀 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2 <u>K</u> INo S	pecify:		Sp	ecify: Wh	ite	
21215-0036	72 ho	Completed by	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Deced	dent's Usua kind of wo	al Occupation	n Ig most of worki	ng	16b. Kind	of Business/Inc	dustry	
121	within lene. than	Ig II	Elementary/Secondary (0-12)	College (1-4or 5+)						7.7			
	filed within 72 hours after death with the Maryland Hygiene uthar than "natural", or Itams 23a or 28a-f show uthar than "hadical Exactronal be notified at		12 17. Father's Name (First, Middle, Last	•)	ULL	ice M	anager	Mother's Name	/First Middle		nding		
anc	ntal l	Be c	George Gibson Ru						e E. Fr		,,,a,,,		
Maryland	2 should be and Mental is marked o	2	19a. Informant's Name/Relationship		19b. Mailir	na Address	(Street and	Number or Rura			own, State, Zip	Code)	
N S	and 2 sealth ar n 27 is ier trau		Pamela A. Ruby /	•		10:		Lane,				,	
re,	ss 1 and 2 of Health I itam 27 i		20a. Method of Disposition	20b.	Place of Dispo	sition (Nan	ne of		ate		tion - City or To	wn, State	
E O	Page ent o nt: # ry or	-	1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Speci	□Removal from State fy) Ba	ayview (			6/1/0	5	Balti	more, M	larvlar	nd
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "naturat", or itams 23a or 28a-f show any injury or other traumatic evant. If a Medical Eracin at most be notified at once.		21. Signature of Funeral Service Lice				d Address of		bbard F				
m	Departing any in once	1	Muhan	reland	4	107 W	Ilkens	Avenue	, Balti	more,	Maryla	nd 212	229
			23a. Part1. Et er the disease, or con shock, or heart failure. List only	plications that caused the decone cause on each line.	ath. Do not ent	er the mod	le of dying, su	uch as cardiac c	or respiratory ar	rest,		Approximate Interval Betw Onset and D	veen
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	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):		,						
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Ć,	be executed ician and burial-transit	Еха	resulting in death) Last	C Due to (or as a conse	equence of):								
760,	ires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit	cal		_ d									
99	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as if	Med	IF FEMALE:								<u> </u>		
Вох	th ce tendii or use	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		Ectopic pr	regnancy			230	I. Date of delive Month	,	ear
	e dea the at	by Physician/Med	1 Yes 2 No	4☐Pregnant at time of 9☐Unknown	death 5	Other (sp	ecify)				MORITI	Day 1	ear
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or	w requir been si should	etec											
Records,	has ge 2	Completed							24a. Was autop perfor	med?	4b. Were autor prior to cor death?	npletion of ca	use of
a	n: Th ficate or, pa		DE Was one referred to modical	<u> </u>					1 ☐ Yes	2 <b>X</b> No	1 🗆 Yes	2□ No	
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1  Yes 2  No	Hospital: 1 ☐ Inpatient 2[	□ EB/Outpation	t 3 DC	Othor	Place of Death  Whursing Hor			Other (Caseif	-1	
of	Phy er this	n; To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		8c. Injury at Work?		28d. Describe h			7	
ion	Attanding r death. ector: After by the fune	atloi	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury	М		2 🗆 No					
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O	tal or	Certification;	, and the same of	building, etc. (Spec	y)				Only or Ton	n, olalo)			
	To tha Hospital or Attanding Physician: The law within 24 hours after death.  To tha Funaral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 ☐ Certifying Pi (Check only one) 2 ☐ Medicel Exa	hysician: To the best of my kr miner: On the basis of examir and manner stated.	nowledge, death nation and/or inv	occurred restigation,	at the time, d , in my opinio	ate and place, a n, death occurr	and due to the ded at the time, d	ause(s) an date and pla	d manner as stace, and due to	ated. the cause(s)	
	o tha o tha omple	Med	29b. Signature and title of certifier	and mailler stated.		290	. License nu	mber		29d. Date s	igned (Month, L	Day, Year)	
	F S F Ö		1 Surker	lais	-		0210	49		Mai	131	2005	
0	1		30 None of address of according	completed cause of death (It	əm 23a) (Tvpa.	D-i-4)					·		
7	) "		SAMBANDAM BA	SKACAV 314.  32. Registrar's Sign	55 WIL	KEN	IS AVE	BA	LTIMO.	RE.	MD 21	229	
	Sta	atė	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ure	K	board	1					
	Regist	rar	J	UN 0 6 Knns	Miller	15.	1						

/Medic Examin	an	1. Decedent's Name (First, Middle, Last) ANNETTE C. ROBINSON			2. Date of Death Month D	ay Year 3.	150 AN
		4a. Facility Name (If not institution, give street and number)	1 1 6	4b. City, Town, or Location of Death	1 / 4	c. County of Death	P
		Maryland Greneral L	tospital	Baltimore C	144	N/A	
uneral irector		5. Social Security Number  214-86-5941  Usual Residence of Decedent	e (In §rs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea. 5-17-1967	r) Country)	(State or Foreig
MO TE	ŀ	10a. State 10b. County	10c. City, Town or Lo	ocation	····	10d. Ir	side City Limits
181-98 Liffed	Director	MD. N/A	BALTIMO	RE			Yes 2 □ No
3e or 2	i Dire	10e. Street and Number 734 N. CARROLLTON AVE.		10f. Zip Code 21217	10g. C	Citizen of What Country? USA	
id other than "neturel", or liems 23e or 28e-f show event, the Medical Evantant must be notified at	by Funerai	11. Marital Status  12. Was Decedent E Armed Forces?  1 Yes Sive If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - American In Black, White, etc. Specify: BLAC	
neturel dicul Ex	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during most of working	16b.	Kind of Business/Industry	′
then a Me	ompi	Elementary/Secondary (0-12) College (1-4or 5	5+)	DO NOT use retired)		EOOD	
other ent, I	a)	-120- 17. Father's Name (First, Middle, Last)			(First, Middle, Maide	FOOD en Sumame)	
s marked o	To B	JAMES ROBINSON		CLOTE	DAWKINS		
	i I	19a. Informant's Name/Relationship (Type, Print)	3	ng Address (Street and Number or Rura			
item 27 other tr	1	CLOTE DAWKINS (MOTHER)  20a. Method of Disposition		4 N. CARROLLTON AV sition (Name of matory or other place)		JRE MARY LAN Location - City or Town,	
ortent: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		matory or other place) REMATORY 6-2-2		LTIMORE, MAF	
Importer any Injur		21. Signature of Funeral Service Licensee JONATAAI	N D. HIBNE	RNAme and Address of Facility PHI 721-27 N. MONROE S	LLIPS FUNI	ERAL HOME, F	.A.
physician and ledical aminer street burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to limin-sulate cause. Enter Underlying Cause (Disease or injury that initiated events	Pneur a consequence of):	Respiratory Failur	e	One	et and Death
by the attending p tached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day	Year
Δ to	leted by Pł	Part II. Other significant conditions contributing to death be	ut not resulting in the u	inderlying cause given in Part I.	23e. Did tobacco	o use contribute to the ca	use of death?
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) SMITH Month Day Vaar **Physician** 06 02 DS /Medical 4b. City, Town, or Location of Death 4c. County of Death ot institution, give street and number) Examiner HOSPITAL OURS ALTIMORE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 38-250 Months 1⊠M 2□F NORTHC Director AUG,10, Usual Residence of Decedent Manyland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic evant, the Medical Examiner must be notified at 1 Yes 2 No Director og. Citizen of What Country? 10e. Street and Number SHBURTON or Itams 23a Be Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 22 No Specify: Specify: BLACK 4 Divorced 3 Widowed "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If tam 27 le markad other than "na any Injury or other traumatic even" College (1-4or 5+) ementary/Secondary (0-12) OTHGRADE DRIVER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HINES -LORENCE 2 19b. Mailing, Address (Street and Number or Rural, Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DAUGHTER BALTIKRE MD. 21223 AREN 20b. Place of Disposition (Name of cemetery, crematory pr other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 06-08-05 OWINGS MILLS, MD. RISON FOREST 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee BROWN JR. FUNERALHONE BALTO. TON AVE. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician monAR /Medical Due to (or as a consequence of): Examiner AS BE STOSI Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23s. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 1 ☐ Yes 2 ☐ No 1 🗌 Yes 212 No the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manne of Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Division Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 06-02-05 541430

Registrar

State

gistrar's Signature

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RANDALLSTOWN M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

31. Date filed (Month, Day, Year) JUN 0 6

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month JUNE **Physician** ALMA L. SOSSICH 2005 2:30 AM /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner MANOR CARE NURSING HOME ROSSVILLE BALTIMORE 8. Date of Birth Month Day, Year) 1-28-1914 9. Birthplece (State or Foreign Country)
ILLINOIS If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. lest birthdev) 6 Sex **Funeral** Months Days Hours 1 M 2 X F 344-03-8897 91 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Madical Examiner must be notified a BUCKS BENSALFM 1 XYes 2 No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 4201 ROBERTS CIRCLE 19020 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐XNo Specify: Specify: WHITE ۾ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) SEAMSTRESS TEXTILE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Lest) Be ALBERT. (STRAIN) ATM ANTOINETTE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) PATRICE SAYLOR/ DAUGHTER 1304 WEST JARRETTSVILLE ROAD FOREST HILL, MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 6-6-05 BENSALEM 22. Name and Address of Facility CVACH ROSEDALE FUNERAL HOME 21. Signatu Funeral Service Licensee 1211 CHESACO AVENUE ROSEDALE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Completed by Physician/Medical Examine The law requires that the death certificata be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 Yee 28 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has b irector, paga 2 s 1 Ves 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completaly filled in by tha funaral director, 8 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3□ DOA 28b. Time of 28c. Injury at Work? 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) Medical Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature end title of certifier son who completed cause of deeth (Item 23e) (Type, Print) Name and address of pe RD Stein -845 Datwood

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State Registrar

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of	Phys r this ral dii	은	examin 1 🗌 Ye 27. Manne 1 💽 Na	es 2 N er of Death	5 🗌 Pendii	ng		XInpatier te of Injury onth, Day		ER/Outpation 28b. Time Injury	of	28c. Injun Worl	y at k?	2	ne 5 Re 28d. Describ				fy)	
Division	or Attan after deat Diractor: in by the	Certification:	2 ☐ Ad 3 ☐ St 4 ☐ He		6 Could determ	igation not be nined	28e. Pla	ace of Injui	ry - At h . <i>(Speci</i> i	ome, farm, s fy)	M street, facto		Yes 2□	-		(Street a own, Stat		nber or Rur	al Route Nur	mber,
	e Hospital 24 hours a Funaral letely filled	edical C	29a. Certif (Chec one)	ck only				bas s of	examina						and due to the				stated. to the cause(	(s)
)	To the within 2 To tha complet	Me	€90. Signa	iture and ti	Ne of certifie	10	1	A		- M	25	c. License	number	52		29d. D	ate sign	ed (Month,	Day, Year)	5
	12		30. Name	and addre	ss of person	who con	np ted ca	ause of de	ath (Iter	n 23a) (Type	Print)	MINT	Tr	/A. t.	1221	4001	116	in	307	1
	Sta	ite			, Day, Year	)	32	-	r's Signa	ature	land.	PIVII	IUN	VIT	1001	n a	()	· 10 .		7
	Registi	ar			JUN U	6 20	03	Older	w.	D. A	1									

State of Maryland / Department of Health and Mental Hygiene  1- For State Registrer  Certificate of Death  Reg. No. 0 5								10706		
			Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death		Dealii	Reg. No. 2. Date of Death 3. Time of Death			
	Physici /Medio		Willie Max	ine 1	LZZ	le		June	Day Year	4:45 AM
	Examir		4a. Facility Name (If not institution, give stree				or Location of Death		4c. County of Death	1
				al Coente			imore		N/	4
	Funeral Director		5. Social Security Number 6.*Sex 1 M	7. Age (In yrs. I	last birthday) I Yrs.	Months Days		8. Date of Birth (Month, Day, Y	(ear) 9. Birth Con	place (State or Foreign intry)
			Usual Residence of Decedent					June 15,	1137	VA
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depurtment of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23e or 28e-1 show any injury or other traumatic avant. In Medical Example, or other traumatic avant. In Medical Example, or other traumatic avant.	by Funeral Director	10a. State 10b. County		, Town or Lo					10d. Inside City Limits 1
Maryland 21215-0036			MD N/A		alti	more		1		
			10e. Street and Number 3958 Penhur	as L Dua		10f. Zip Code	215	100	J. Citizen of What Co	untry?
			11 Marital Status 12.	Was Decedent Ever in U.			Hispanic Origin? (Spotan, Mexican, Puerto	ecify Yes or No-	14. Race - Amer	
		/ Fui	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 ☑ No		rican, etc.)	Black, White	1 1 .
		d be	3 Novidowed 4 Divorced	Year or Dates:		dent's Usuaf Occu			0	lack
		plete	15. Decedent's Education (Specify only highest grade co	mpleted)	(Give	kind of work done  DO NOT use retire	ipation 9 during most of work 9d)	ing	b. Kind of Business/I	ndustry
		To Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Nurs	e		Private	Duty
			17. Father's Name (First, Middle, Last)	s 1.				e (First, Middle, Ma		,
			Dallas T. Bl.  19a. Informant's Name/Relationship (Type,		10b Maili	na Address (Stras		elmina	BISCK Dity or Town, State, Z	in Cordal
<b>≥</b>			Cynthia Winkler	/ 1	291	-0.5			v2 4.1	DISIS OM DANS
ē,			20a. Method of Disposition	20b. P		sition (Name of matory or other pla			c. Location - City or 1	
Ë			1 D Burial 2 ☐ Cremation 3 ☐ Remo `4 ☐ Donation 5 ☐ Other (Specify)	oval from State		ion Cem		3/05 L	ansdown	e MD
Baltimore			21. Signature of Funeral Service License					Funera	1 Service	e, P.A.
	certificate be executed horizontal by Medical Examiner and horizontal se as the buriat-transit		23a. Part1. Enter the disease, or complicati	ons that caused the death	Do not ent	5126	Belour	Road, 13	a/4more	MD 01500
Ш			shock, or heart failure. List only one c Immediate Cause (Final	ause on each line.	C.			or recognitions		Approximate Interval Between Onset and Death
			disease or condition resulting in death)	Due to (or as a consequ						3 days
01			Sequentially list conditions, b. —	Sacral Decubitus Ulcer					5 months	
		nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
Ć,		Examiner	that initiated events c							
8760,		dical	d							
9	ertifica ling ph e as ti		IF FEMALE:			7.67				
Box	To the Hospital or Attanding Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as:	clan	in the past 12 months?	If yes, outcome of pregna 1□Live birth 2□Fetal 4□Pregnant at time of de	death 3	Ectopic pregnand Other (specify)	су		23d. Date of deliving Month	rery Day Year
0		by Physiclan/Me		9☐ Unknown						
s, P			14 14					23e. Did tobac	e. Did tobacco use contribute to the cause of death?	
ord		ted	Multiple Myeloma				1 🗌 Yes	1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown		
Sec		Certification: To Be Completed by	End Stage K	enal Dis	ease			24a. Was an autopsy performe	24b. Were aut prior to cod? death?	opsy findings available ompletion of cause of
a			25. Was case referred to medical				00 DI (D )	1  Yes 2		2 No
Ξ			examiner?  1 Yes 2X No Hosp	nital: 1 Inpatient 2 🗆	ER/Outpatier	nt 3 DOA	hor	n <i>(Check only one)</i> me 5 □ Residend	ce 6 □Other (Speci	fv)
Division of Vital Records,				8a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Inju		28d. Describe how		<i>,</i> ,
Sio			2 Accident investigation	Discount to the second			Yes 2□No	004 1 (04		
Div		ertif	4 Homicide determined	Se. Place of Injury - At ho building, etc. (Specify	me, rann, su /)	еет, тастогу, отнов	'	City or Town, S	et and Number or Rur State)	ai Houte Number,
		salc	29a. Certifier  (Check only  (Check only  29 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
		Medical	one) and manner stated.							
			29b. Signature and title of certifier	ton mi	)					
,	N		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							
Y	5 Jackson Hamilton 3001 South Hanover Street Baltimore Maryl							Marylan	d 21225	
	Sta Registr		MIN O C GOOT WAS AS AS AS AS							

amend item#21 Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			,	Cer	tificate of	Death	,	Reg. No.	5 10707	
	Physician	Decedent's Name (First, Middle, La	HESTER	R WIN	FIELT	>	2. Date of De Month	Dey	Year 5-05 PM	
	/Medical Examiner	4a Fecility Neme (If not institution, give				4b. City, Town, or I	Location of Deat	th 4c. County of		
1	Funeral Director	S'ANDTOWN WINCHESTER NURSINGHOME BALTIMORE NA								
1		212 207102	Sex 7. Age (In 92 F	yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bi (Month, Da 02-01-	rth ay, Year) 1913	9. Birthplece (State or Foreign Country)  MD	
	pug M	Usuel Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits								
	Maryli f sho	MD	N/A	BALT					¥∏ Yes 2 □ No	
	vith the Mar n or 28a-f s be notified Director	10e. Street end Number			10f. Zip Code			10g. Citizen of Wh	net Country?	
	3a or	1536 MCKEAN AVE	MITE		1.00	217		USA		
	me 2	11. Maritel Status	12. Was Decedent Ever	in U,S. 13. V		Hispenic Origin? (S an, Mexican, Puert	pecify Yes or No		- American Indian,	
Baltimore, Maryland 21215-0036	should be filled within 72 hours efter death with the Maryland and Mentel Hygiene.  marked other than "natural", or items 23s or 28s-f show amatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes XX No If Yes, Give Yeer or Dates:	1	Yes, specify Cub		o Mican, etc.)		White, etc. BLACK	
5-0	72 ho metur acal	15. Decedent's Ed (Specify only highest gre	ducation	16a. Deced	ent's Usuel Occup	petion during most of wor	rkina	16b. Kind of Bus	iness/Industry	
21	be filed within 72 hou tel Hygiene. d other then "netura event, the Medical I. Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of wor d)		TI O II O DI II		
2	CO Profile	17 Estharia Nama /First Middle I set	1	DOM	DOMESTIC 18 Method's New		no /First Middle	HOUSEWORK		
and	and of other several Be	CATTY					WASHINGTON			
Ž	hould d Men marke	JOHN WASHINGTON  19a. Informent's Name/Reletionship (	Type Print)	19h Meilin	n Address (Street			per, City or Town, S	tete Zin Code)	
M	Ith er 27 is 1 trau	HILDA DIGGS/NIEC						, MD 212		
ē,	permit. Pages 1 end 2 should be filed withir Department of Health end Mentel Hygiene. Important: if item 27 is marked other than any Injury or other traumatic event, the Monce.  To Be Compi	20a. Method of Disposition	2	0b. Place of Dispos	sition (Name of natory or other pla	cal	Date	20c. Location - C	ity or Town, State	
Ë	Page ent o nt: If i	1 ABurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	ARBUTUS 1	MEM. PK	6		BALTIMORI		
alti	mit.	21. Signature of Funeral Service Licer		22	Name end Addre	ess of FecilityJA	IES A. M	ORTON & S	SONS F.H., INC	
Ω	Dep impo	James A Morton II								
		23a. Part1. Enter the disease, or com shock, or heart failure. List only		death. Do not ente	or the mode of dyi	ng, such es cardiac	or respiratory a	irrest,	Approximete Interval Between	
	Physician								Onset and Death	
1	/Medical Examiner	Immediate Ceuse (Final disease or condition e. A THEROSCLEROCIC CARDIOVASCULAR DISEASE YEARS resulting in death)								
		resulting in death)		to (or as a conseq						
	rificate be executed no physician and a set the burial-transit	<b>b</b>								
Ć.	rifficata be executed ng physician and a as the burial-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events Due to (or as a consequence of):								
68760,	ıta be nysicia he bu									
-	ing ph a as t	resulting in death) Last								
Box	aath cer attandir for usa		d							
	that tha daath ce ad by the attand detached for us	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death?		
P.0	ad by detac						10	1 Yes 2 No 3 Probably 4 Onknown		
Division of Vital Records,	The lew requires that tha daath ce the has been signed by the attandi pege 2 should be detached for uss completed by Physician/I						24a. Was	an autopsy	24b. Were autopsy findings	
S	been si should leted							ormed?	available prior to completion of cause of death?	
Be	e has						317	Yes 2016	1 Yes 2 No	
ta	ysician: The l s certificate ha director, pege To Be Com	25. Was case referred to medical 26. Place of Death (Check only one)								
Į ×	ysich Is cer direc	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outpatient	3□ DOA Oth	_		idence 6 □Other	(Specify)	
0	Attending Physician: r death. ector: After this certificity the funerel director, by the funerel director, ification: To Be (	27. Menner of Death 28e. Dete of Injury 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Work?								
<u>i</u>	auth. or: Af he fu	2 Accident No 1 Yes 2 No								
Ž	or Atta	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - building, etc. (S)	At home, farm, stre pecify)	et, factory, office		28f. Location (Street end Number or Rural Route Numb City or Town, Stete)		or Rural Route Number,	
	pital cours a	20a Codifier	as Dhuslalan. To the best of my knowledge death occurred at the time date and also and the size of the							
	To the Hospital or Attending Physician: The lew requires that the death ce within 24 hours eftar death. To the Funerel Director. After this certificate has been signed by the attand completaly filled in by the funerel director, page 2 should be detached for us:	29a. Certifier  (Check only one)  2   Medical Examiner: On the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated.  (Check only one)  2   Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end menner steted.								
	within 2 To the comple	29b. Signature and title of certifier	4	,	29c. Licens				'Month, Day, Year)	
) .	0/	1/20 Vasav	thalum	DINA	04	12510		JUNE	03, 2005	
		30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print)  NOVASANTUA KUMAN MD, 821. N. EUTAW ST. SUITE 407, MD21201								
	State Registrar	31. Dete filed (Month, Day, Year)  JUN 0 6	32. Registrer's S	Signeture	perti					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** ARREN Year 1:15am м 06 3 2005 /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Lorien-Frankford N.H. If Under 24 Hrs.
Hours Min. 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1□M 2√2F 239-44-3508 Yrs Director 9-10-27 N.C. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28a-f show eny injury or other treumatic event, the Nedical Examinal must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 □ No Director Baltimore Md NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21217 1331 Divison Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 □Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Be Completed by Specify: 3 Widowed 4 □ Divorced Black Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Crossing Guard Baltimore City School 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Barnett Louisina Wiley Balton ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Warren Son 5402 Gardenwood Road, Baltimore, Md. 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cem. 6-8-05 Anne Arundel Co., Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21202 Baltimore, Md. March F.H. East 1101 E. North Ave. /le 23a. Part1. Enter the disease, or compli-tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCUD Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying by Physician/Medical Examiner Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 4 Junknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an autopsy perform Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No funeral director, page 2 1 Yes 3 25. Was case referred to medical examiner? Be 26. Place of Beath (Check only one, Hospital: Other: Certification; To 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation after death. 1 🗌 Yes 2 🗌 No

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Box 68760. Division of Vital Records, P.O.

State

DHMH 17 Rev 1/2001

filled in by the

Medicai

24 hours a

within 2 To the

Registrar

31. Date filed (Month, Day, Year)

and title of certifier

6 ☐ Could not be

determined

2 Accident

3 🗌 Suicide

29a. Certifier

29b. Signatu

4 T Homicide

201

npleted cause of death (Item 23a) (Type, Print)

and manner stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 1 - Stata Ragistrar Certificate of Death Decedent's Name (First, Middle, Last) ELSIE FLIZABETH 2. Date of Death WEISS **Physician** JÜNE 200<sup>Y</sup>5° 6:40A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner. MANOR CARE NURSING HOME ROSSVILLE ROSEDALE BALTIMORE If Under 1 Year | If Under 24 Hrs. Social Security Number 216–18–4917 8. Date of Birth 1 - 9 - 1921 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 □ M 217 F 84 Director MARYLAND Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28e-f show other treumatic event, the Mudicul Examinat roust be notified at MD BALTIMORE ROSEDALE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1503 WEYBURN ROAD 21237 items 23g U.S.A. death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filled within 72 hours after or and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: WHITE by Specify: 3 Widowed 4 Divorced ted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Comple Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY MOTOR VEHICLE ADM. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MAYNARD BEHLER GRACE (TRACY) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PEGGY LANGLEY/ SISTER 8063 ROSLYN AVENUE item 27 i ROSEDALE, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State METRO CREMATORY \* 4 ☐ Donation 5 ☐ Other (Specify) 6-7-2005 CATONSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME ROSEDALE, MD 1211 CHESACO AVENUE 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a RUPTURED ARDOMINAL AORTIC ANEURYSM disease or condition resulting in death) 15 min /Medical Due to (or as a consequence of) **Examiner** ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 15 Yrs. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months?
1 Yes 2 No ō Day 4☐Pregnant at time of death 5 Other (specify) P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Chronic Obstructive Pulmonary Disease Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an has page 2 autopsy performed? 1 Yes 2 No Division of Vital 1 Yes 2X No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funerel Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. D17728 June 6, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ba Yin Oung, M.D. 8022 Belair Rd. Balto., MD 31. Date filed (Month, Day, Year) State Registrar

		-	State of Maryland / Department of Health and Mental Handles of of Handles of Health and Mental Handles of	Hygiene Reg. No.: 005 18790	
L	Physicia /Medic	an al	EATHER MIAE OF MAINS	Y 25 205 //30 AM	
	Examin	) 1-200	UNION MEMORIAL HUSPITAL BALTIMURE CITY	4c. County of Death	
- W. - 3	Funeral Director		5. Social Security Number 6. Sex 1 Months Days Hours Min. 0.00 Months Usual Residence of Decedent 6. Sex 1 Months Days Hours Min. 0.00 Months Days Months	f Birth 9. Birthplace (State or Foreign County)  29 - 1 7 16 N - CARO 1 N +	9
	Maryland I show		10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 Xes 2 □ No	
	with the 3s or 28a	I Director	10e. Street and Number	10g. Citizen of What Country?	
36	72 hours after death with the Maryland natural', or items 23c or 28a-f show Jisal Exaction from Le nofflied	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 11. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	r No- 14. Race - American Indian, Black, White, etc.  Specify: Black	
21	E . c ₹	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16b. Kind of Business/Industry	
land 21	should be filed with nd Mental Hygiene marked other tha matic event, Ine h	Be	17. Father's Name (First, Middle, Last)	ddle, Maiden Sumame)	2
Maryla	2 should be and Mental is marked o aumatic eve	5	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Nu		
a)	ges 1 an t of Heal If item 2 or other		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	20c. Location - City or Town, State	<u>Z</u>
Baltimor	permit. Pa Departmen Important: any injury once.		2 Cremation 3 Hemoval Horn State  • 4 Donation 5 Other (Specify)  21. Signature 1 Juneral Service Licensee  22. Name and Address of Facility # 100 CT	000000000000000000000000000000000000000	1207
	* ·		23a. Put Enter the disease, or complications that caused the reach. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  MYUCHTO) BL  TNFARCTION	Unset and Death	
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  A MYUCARDIAL TN FARCTION  Due to (or as a consequence of):  HYDERTENSION	MINUTES YRS	-
	ed sit	niner	Sequentially list conditions,  if any, leading to immediate  Due to (or as a consequence of):	on pisease yas	_
8760,	sate be executed thysician and the burial-transit	Ical Examin	that initiated events resulting in death) Last Due to (or as a consequence of):		
Box 6	ath certific titending p or use as f	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year	
ds, P.O.	uires that the de signed by the a lid be detached f	by	Part II. Dutier significant conditions contributing to death but not resulting in the underlying cause given in Part I.	Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown	
of Vital Records,	sician: The law requir s certificate has been si lirector, page 2 should I	Completed	BREAST CANCEN, HISTORY UP STRUKE 24a. V	Was an autopsy seriormed? es 2 № Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	,
f Vita	ysician: is certific director,	To Be (	25. Was case referred to medical examiner?	nly one) Tesidence 6 □Other (Specify)	
ion of	nding Physith.: After this funeral di			ibe how injury occurred	
Division	al or Atter after des Director d in by th	Certification:	3 Suicide 4 Homicide  3 Suicide 4 Homicide  3 Suicide 4 Homicide  4 See Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	on (Street and Number or Rural Route Number, r Town, State)	
	To the Hospital or Attending Physician: The Within 24 hours after death.  yo the Funeral Director: After this certificate h.	Medical C		the cause(s) and manner as stated. me, date and place, and due to the cause(s)	
	To the comp	Me	29b. Signature and title of certifier  D2639	29d. Date signed (Month, Day, Year)	
	16)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DO NOW) TWEGEN 6569 N, CHARUS ST #6	111 21204	
1	Sta Regist		0 0 211115 /64		

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373	7		1 - State Unpend Ite	State of Mem 23a,pt.II	laryland / Depa ,27,28a-f	artment of H er. me G84	lealth and 4 6-15- Death	Mental Hyg 05 tas	iene	5 18791
			Decedent's Name (First, Midd.					2. Date of Deat	th	3. Time of Death
	Physici /Medi		Darnell	L	uther	Will:	iams	Month MAY	31, 200	Year 0930 A M
	Examir		4a. Facility Name (If not institutio	n, give street and number,	)	4b. City, Town, or	Location of Dea	ath	4c. County of	
200			838 N. FULTON		- diameter	BALTIMO:	RE CITY	2 2 2 2 4 2 1 2 1		
7	Funeral Director		5. Social Security Number 217-84-1715	6. Sex 7. A	ge (In yrs. last birthday) 42 Yrs.	Months Days	Hours Mir		Year)	Birthplace (State or Foreign Country)      MD
• /	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary -1 sh	tor	MD NA	7	Baltimo	ro				TY⊈Yes 2 □ No
	death with the Maryland ms 23a or 28e-f show rnust be notified at	Director	10e. Street and Number		Darcino	10f. Zip Code		1	0g. Citizen of Wh	nat Country?
	ath wi		1100 Pennsyl	vania Ave	Apt 805		21201		U.S.	Α
	er de:	Funeral	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? ( n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race	- American Indian, , White, etc.
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Heath and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28e-1 show or other treumatic event, the Madical Examiner mast be notified at	þ	1X Never Married 2 Mar 3 Widowed 4 Divorced	If Yes Give		1 ☐ Yes XXNo	Specify:		Specify:	Black
9-0	72 hou	Completed	15. Deceder	nt's Education est grade completed)	16a. Dece	dent's Usual Occupa	ation	advina	16b. Kind of Busi	iness/Industry
21	ithin 79.	nple	Elementary/Secondary (0-12)	College (1-4or	life.	DO NOT use retired	)	orking		
121	iled w tygier her th		10th grade 17. Father's Name (First, Middle,	na na	U	nemploye		(First Middle 1		nployed
anc	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the Me	Be c		·				ame (First, Middle, I	Maiden Sumame)	
Ž	should ind Men s marke umatic	은	Luther Willi  19a. Informant's Name/Relations		19b. Maili	ng Address (Street a	Elsie	Brown Bural Route Number	: Citv or Town. St	tate, Zip Code) 21201
	nd 2 : alth ar 27 Is		Elsie Blake-M	lother						Balto, Md
Baltimore,	permit. Pages 1 and 2 Department of Heath a Important: If item 27 is any injury or other tre once.		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place		Date	20c. Location - Ci	ity or Town, State
Ē	Page nent c		XXBurial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (5		Mt. Zior	*	' I	6/05 E	Baltimo	re, Md
alt	permit. Departr Importa any inju		21. Signature of Funeral Service	Licensee	) 22 M	Name and Address	s of Facility			
-	20 E E 3		23a. Part1. Enter the disease, o	telmon	4.	300 Waba	sh Ave	, Balti		1d 21215
8760,	/Medical Examiner bhisician and sthe purial-transit	dical Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate first Interview Cause (Disease or injury that initiated events resulting in death) Last	a. Heroin  Due to (or as  b  Due to (or as	and Ethano s a consequence of): s a consequence of): s a consequence of):	l Intoxica	ation			Interval Batween Onset and Death
P.O. Box 68	it the death certific by the attending p tached for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (s <i>pecify</i> )			23d. Date o	
ds, F	puires than signed and all the del	d by P	Part II. Other significant conditi	ons contributing to death I	but not resulting in the u	nderlying cause give	en in Part I.		_	ute to the cause of death?
O	aw requi	olete						24a. Was a	n 24b. We	are autopsy findings available
Vital Records,	icien: The lav certificate has ector, page 2	e Completed by							ned? dea	or to completion of cause of ath? Yes 2 \sumbox No
	ysicien: is certific director,	To Be	25. Was case referred to medica examiner?   X Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 ER/Outpatier	nt 3 DQA Othe		eath <i>(Check only one</i> Home 5 🗆 Reside		(Specify) SCENE
Division of	iding Phy th. After this funeral o		27. Manner of Death 1  Natural 5 Pendin	28a. Date of Injury	ury 28b. Time o	f 28c. Injury Work	at	28d. Describe ho		
Divisi		Certification;	3 Suicide 6 X Could 4 Homicide determ	not be nined 28e. Place of in building, e	ijury - At home, farm, str tc. (Specify)			28f. Location (Str City or Town Baltimor	reet and Number 1, State) 838 ce, Md	N. Furton Ave
	To the Hospitel or within 24 hours after To the Funeral Dircompletely filled in	Medical	29a. Certifier  (Check only one)  1 ☐ Certifyin  2 ☑ Medical	ng Physician: To the best Examiner: On the basis of and manner st	of examination and/or in	h occurred at the tim vestigation, in my op	e, date and plac pinion, death occ	e, and due to the ca curred at the time, da	use(s) and mann ate and place, and	er as stated.  d due to the cause(s)
	To the within 2 To the complet	W	29b. Signature and title of certifie	) con ice	-Rock.	29c. License				Month, Day, Year) 2005
			30. Name and address of person	Aronica-t	death (Item 23a) (Type,	111 Peni	n Street	Baltimo	ore, Mary	yland 21201
	Sta Registi		31. Date filed (Month, Day, Year, JUN 0 6 2	2005	rar's Signature	de				

			. FOI	partment of Health and Nertificate of Death	Reg. No. UU5	18792
ı	Physici		Decedent's Name (First, Middle, Last)     MILDRED	WIENER	JUNE 1, Day 2005	3. Time of Death 4:07 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL	4b. City, Town, or Location of Death		N/A
	Funeral Director		5. Social Security Number  213-03-5558  0. Sex 1	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	9. Bir (Month, Day, Year) 916	thplace (State or Foreign ountry) MD
	Maryland -f show ibd st	tor	10a. State         10b. County         10c. City, Town or           MD         N/A         BAL	Location TIMORE		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the ta or 28a Lee notifi	Direc	10e. Street and Number 7111 PARK HEIGHTS AVENUE #609	10f. Zip Code 21215	10g. Citizen of What Co	ountry?
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23a or 28a-f show avant, Ite Mcdiral Examinar must be maiffied at	by Funeral Director		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Pican, etc.) 14. Race - Am Black, Whi Specify:	erican Indian,
Maryland 21215-0036	within 72 hou ene. than "natura he Modical E	Completed	(Specify only highest grade completed)  (Specify only highest grade completed)  (Signal (1-4or 5+)  (Signal (1-4or 5+)	edent's Usual Occupation re kind of work done during most of work DO NOT use retired) PRIETOR	1	/Industry
and 2		Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Sumame)	
Maryl	d 2 shouth and N is man	To	19a. Informant's Name/Relationship (Type, Print)  19b. Ma	iling Address (Street and Number or Ru	Tal BALLE TIMORE of MAD. State.  UST BLDG 2 HOPK	Zip Code) 21201
Baltimore,	& ° = 5		20a. Method of Disposition  1 🛱 Burial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)	RIENDSHIP CEM 6/3/		ORE, MD
Balt	permit. Pag Depintment Impintant: any injury one.		21. Signature of Funeral Service Licensee		L LEVINSON & BROS. ROAD - PIKESVILLE,	
	Pnysician /Medical Examiner		resulting in death)  Due to (or as a construence of):	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Opset and Death Constant Source C
8760,	death certificate be executed e attending physician and dor use as the burial-transit	ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniterlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Que to (or as a consequence of):  Due to (or as a consequence of):	& de aydration		72-li.
.O. Box 6		Physician/Medical		DEctopic pregnancy Other (specify)	23d. Date of de Month	livery Day Year
ds, P	w requires that been signed be should be det	by	Part II. Other significant conditions contributing to death but not resulting in the	1	23e. Did tobacco use contribute t 1 ☐ Yes 2 🎇 No 3 ☐ P	o the cause of death? robably 4 Unknown
Vital Records,	The la ate has page 2	Completed	premount Parlacourn' Ry	so Lyperdosu.	autopsy prior to performed? death?	utopsy findings available completion of cause of
Division of Vita	or Attending Physician: ifer death. Director: After this certific in by the funeral director.	Certification; To Be C	25. Was case referred to medical examiner?  1  Yes 2 No	ent 3 DOA Other 4 Nursing Hoof 28c. Injury at Work?  M 1 Yes 2 No	th (Check only one) ome 5 Residence 6 Other (Special Countries of the Coun	
_	To the Hospital within 24 hours a To the Funeral I completely filled	edical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause(s) and manner a rred at the time, date and place, and du	s stated. e to the cause(s)
)	withir To th	Me	29b. Signature and title of certifier  With Reul X Werm MP	29c. License number	29d. Pate signed (Mon.	th, Day, Year)
4	5		30. Name and address of person who completed cause of death (Item 23a) (Typ  MWATL LEVIN MD 28	8, Print) SM171 A	& # 207, V BA	10 2120g
D.	Sta Regist	rar	31. Date filed (Month, Day, Year)  JUN 0 6 2005  32 degistrar's Signature	note:		

ORIGINAL

			1 - For Amend Item 24	State of M a <b>per Ve</b> i	aryland / rb.,G84	Depa 4 <b>O</b>	irtment of He 406405dhb	ealth ai <i>Death</i>	nd Mental	Hygien	e005	18793
			Decedent's Name (First, Middle, Last,	)			<del></del>		2. Date	of Death		3. Time of Death
	Physici		VIRGINIA MAE	ANDRE					Month		2005	7:30 AM
	/Medio		4a. Facility Name (If not institution, give				4b. City, Town, or	Location of			c. County of Deal	
	LAGITIII		9246 CRESCENT	T.ANE			LA PI	ΔπΔ			CHAR	TEC
	Funeral		5. Social Security Number 6. Sec		je (In yrs. last b	oirthday)	If Under 1 Year	If Under 2		of Birth	9. Birt	hplace (State or Foreign
	Director		163-22-8339	м жж	77	Yrs.	Months Days	Hours	Min. (Mont	n, Day, Yea	r) Co	OHIO
	D		Usual Residence of Decedent						1001		. 1 . 2 . 7	
	72 hours after death with the Maryland neturel', or items 23a or 28a-f show dical Examiner must be notified at		10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits
	Ma-fs	Director	MARYLAND CHAR	LES	T, A	PL	АТА					1 ☐ Yes 2 No
	n the	irec	10e. Street and Number		1 1111		10f. Zip Code			10g. C	itizen of What Co	untry?
	3a o	<u></u>	9246 CRESCENT	LANE			206	46			U.S.A.	
	death ms 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. V	Vas Decedent of His	panic Origi	n? (Specify Yes	or No-	14. Race - Ame	nican Indian,
(0	ifter in the	교	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X			Yes, specify Cuban		Puerto Rican, etc	:.)	Black, White	e, etc.
8	urs a	þ	3 ♥ Widowed 4 Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2\OXNo	Specify:			Specify:	WHITE
21215-0036	2 ho	Completed	15. Decedent's Edu	cation	16	a. Deced	lent's Usual Occupat	tion		16b.	Kind of Business/	Industry
2	within 7 ene. then "n	pie	(Specify only highest grad	College (1-4or	5+)	life. L	kind of work done du DO NOT use retired)	iring most o	of working	Ü	J.S. GO	VERNMENT
2	d wit	ПО	12	50 <b>.55</b> (1		ECR:	ETARY			D	EPT. O	f ARMY
	be filed ital Hygi id other event, II	Bec	17. Father's Name (First, Middle, Last)	-				18. Mother	s Name (First, Mi	ddle, Maide	n Sumame)	
<u>a</u>	Menta Menta Brkad atic ev	To E	PAUL SNOPIK					MΑ	RY ANN	HENR	Υ	
Maryland	A B E E	<b></b>	19a. Informant's Name/Relationship (Ty	rpe, Print)	19	b. Mailin	g Address (Street ar	nd Number	or Rural Route N	umber, City	or Town, State, 2	Zip Code)
	and 2 saith a n 27 is		DENISE_M. MC DO	OWALL-DA	AUGHTE	R (	9246 CRE	SCEN	T LAME	T. 25	DIAME.	MARYLAND
ā,	of Health item 27 othar tra		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of natory or other place		Date	20c.	Location - City or	Town, State 20646
9	Pages nent of int; if it		Y☐XBurial 2 ☐ Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)				NATIONA	· 1	M 6 1			
altimore,	구두만큼		21. Signature of Funeral Service License		00477		Name and Address		M. 0-1.	1-05	ARLING.	ron, va
ñ	permi Depa Impo any ir		Milal	1	1		RAYMOND	FUNE	RAL SEF	RVICE	' PA	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused	the death. Do		LA PLATA or the mode of dying			206 ory arrest,	46	Approximate
			Immediate Cause (Final	ne caust on each li	ne.		21	0 -				Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to force	a consequence	()	pree	al 7	И			
В	Examiner			Due to (or as	a consequence	9 OI).	1.]					
		e.	Sequentially list conditions, if any, leading to immediate country. Cause (Disease or injury	Due to (or as	a consequence	e of):						
	uted Insit	Ë	Cause (Disease or injury									
	al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence	e of):						
8760,	cate be executed physician and the burial-transit	dicai E										
88	ficate physics the	edic		J								
×	certi	N/	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome	of pregnancy						23d. Date of deli	ven/
Вох	death certiff e attending od for use as	cjai	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pregnancy Other (specify)				Month	Day Year
O.	the y th iche	Physician/Me	9 Unknown	9□ Unknown								
σŽ	The law requires that the has been signed boage 2 should be deta		Part II. Other significant conditions cor	ntributing to death b	out not resulting	in the un	derlying cause giver	n in Part I.	23e.	Did tobacco	use contribute to	the cause of death?
Vital Records,	uires sign	d by								1 □ Yes 2	2□No 3□Pro	obably 4 🗇 Unknown
Ö	w requir been si should	ete							240.1	.÷ Masan	Odb Wess ou	tana diadiana amalahi
Re	ne faw has ge 2 s	Completed							<del></del>   :	utopsy performed?	prior to o	topsy findings available completion of cause of
<u></u>	(Ú 12								1 □ Ý	es 2XN		2 No
₹	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	lospital:			Othor		f Death (Check o			
of	Phys this al di	1 To	1 Yes 2 No	1  Inpatie		outpatient Time of	28c. Injury :	4 LI Nurs			6 Other (Spec	eify)
n		ion	1-Natural 5 Pending	(Month, Da	y Year)	Injury	Work?	a' es 2.⊟No		IDE NOW MI	ury occurred	
<u></u>	Attending r death. actor; After by the fune	ical	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	29a Blace of Ini	une Athoma i	(a.a.at		2 5 140	_	on /Ctreet o	and Morach and a Div	-/ 0
Division	i Site	Certification;	4 Homicide determined	28e. Place of Inj building, et	c. (Specify)	rarm, stre	et, factory, office		City of	r Town, Stat	na Number or Hu 'e)	ral Route Number,
	Hospitel or 24 hours afte Funerel Dira tely filled in t		29a. Certifier 1 Certifying Phys	ricing. To the best	of one kenneda			detail and	-1	45		
	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director; completely filled in by the	Medicai	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Exemination	ner: On the basis of and manner st	f examination a	ge, death ind/or inv	estigation, in my opi	nion, death	piace, and due to occurred at the ti	me, date ar	s; and manner as id place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b Signature and title of certifier	i R-1)			29c. License	number		29d. Da	ate signed (Month	Day, Yearl
1	F 3 F 8		1 / land well				NO.	OFI.	QUQ	4	11510	5
-				malated carrage ( )	leeth (Ita 22 )	\ (T)	DU	- 1/2 V	2011	mic	l n/x	
	b		30. Name/and address of person who co	All I	CL 23a)	(Type, I	07 74	DIO	I w	NJ.	20111	
	Sta	to	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	-1	VZ, NU	PICC	14/11	0	2040	
	اد Registr	100	JUN 0 6 2005	10 D	1 ha	de						
			3011 0 0 2003	MESSAL SC	The same of	-						

		For Amend Item 2 Registrar  Decedent's Name (First, Middle			- Cer	uncate of L	Jean I	2. Date of De		2005	3. Time of Death
hysicia <mark>n</mark> /Medical		DARRELL DEAN ARNO	LD					Month	2L Day	2005	2352 M
xaminer	4	a. Facility Name (If not institution,		iber)		4b. City, Town, or	Location of Dea Air	th	4c.	County of Dea	
neral		5. Social Security Number		7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 Hrs	s. 8. Date of Bir	th	9. Bi	rthplace (State or Foreign
ector	1-	213-40-2149	1 <b>X</b> 3M 2□F	65	Yrs.	Months Days	Hours Min	8. Date of Bir Month, Da 2/14/1	940	No	rth Carolina
A TH	-	Usual Residence of Decedent 10a. State 10b. County		10c. City	/, Town or Lo	cation					10d. Inside City Limits
Med at		MD Harf	ord		Str	eet					1 ☐Yes 2 ☐ No
rai, or tems 23e or 28e-1 show Expulner must be notified at		10e. Street and Number		'		10f. Zip Code			10g. Citi	zen of What C	Country?
s 23e		1320 Heaps Roa		dent Ever in U.	6 12 1	21154		Society Van as Na		USA 14. Race - Am	origan lading
olner nust		<ol> <li>Marital Status</li> <li>Never Married 2 Married</li> </ol>	Armed For	ces? 2 □ No	1	Was Decedent of His f Yes, specify Cubar	n, Mexican, Pue	rto Rican, etc.)		Black, Wh	ite, etc.
À	2	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Da	e Ites: V <b>ietn</b> a	erro	I∐Yes XIXNo	Specify:			Specify: W	hite
Completed		15. Decedent (Specify only highes			(Give	lent's Usual Occupa kind of work done d OO NOT use retired)	uring most of wo	orking	16b. Ki	nd of Business	s/Industry
ompieted		Elementary/Secondary (0-12)	2 College (1-	4or 5+)		REpairma			E 1	ectro	nics
BeC		17. Father's Name (First, Middle, I						ame (First, Middle	, Maiden	Sumame)	
To		Leonard Clay						a1houn			
any injury or other traumatic once.	9	19a. Informant's Name/Relationsh Yukie R. Arno				g Address (Street a. Heaps Ro			e <i>r, City</i> o. 211		Zip Code)
other	1	20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of		Date	20c. Lo	cation - City o	r Town, State
, i		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (Sp		state		natory or other place Crematory		/2005	Leo	la, PA	
OUCE		21. Signature of Funeral Service I	icensee		1000	. Name and Address	- 5 V C - 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5 -	nc.,600 Ma	in St	.,Delta,	PA 17314
	1	23a. Prt1. Enter the disease, or shock, or heart failure. List	complications that	lused the death	n. Do not ente	er the mode of dying	, such as cardia	ac or respiratory a	rrest,	(50051X	Approximate Interval Between
in T	ļ	Immediate Cause (Final disease or condition			on E	in physein	6				Onset and Death
al er		resulting in death)	Due to (	or as a consequ	ence of):	110000					70 9 2007 3
	,	Sequentially list conditions, if any, leading to immediate gades. Enter Under Jing	b	or as a consequ	uence of):						
ai Examiner		cause. Enter Underlying Cause (Disease or injury that initiated events									
Exa		resulting in death) Last	Due to (	or as a consequ	uence of):						
dicai			d.								
Physician/Me		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo						2	23d. Date of de	alivery
icia		in the past 12 months? 1 ☐ Yes 2 ☐ No		rth 2 ∏ Fetal ant at time of de		]Ectopic pregnancy ] Other (s <i>pecify)</i>				Month	Day Year
Phys	-	9 🗆 Unknown						l an Bitte			
2		Part II. Other significant condition  Corenary	- A = 2	Disea		toerlying cause give	п іп Рап І.	239. Did t			to the cause of death?  Probably 4 □Unknown
mpieted	1	Coloning	MACIA	V CSC4				24a. Was		`	utopsy findings available
Completed								auto perfo	psy irmed?	prior to death?	completion of cause of
. O	)	25. Was case referred to medical					26. Place of De	1 ☐ Yes eath (Check only o	No one)	1 1 1 1 9	s 2 No
To Be Com		examiner? 1 ☐ Yes 2 No	Hospital: 1	npatient 2	ER/Outpatien	t 3 DOA Othe	r: 4 Nursing	Home 5 ☐ Resi	dence 6	6 ☐Other (Spe	ecify)
on:		27. Manner of Death 1 Natural 5 ☐ Pending	9	f Injury h, Day Year)	28b. Time of Injury	28c. Injury Work	?	28d. Describe	how injur	y occurred	
/ the r licat		2 Accident investig	not be 200 Diego	of Injury - At ho	me farm str	M 1 ☐ Y eet, factory, office	′es 2 □No	28f. Location (	Street and	d Number or F	Rural Route Number,
Certification:		4 Homicide determine	buildir	ig, etc. (Specif)	()	oot, ractory, office		City or To	wn, State,	)	rata riosto rambor,
Medical C			g Physician: To the Exeminer: On the ba	sis of examinat							
completely filled in by the funer Medical Certification:		29b. Signature and title of certifier	and mann			29c. License	number		29d. Date	e signed (Mon	th, Day, Year)
2		MA	- 11			5.1	2010		Ma	. 77	200-
		'	LU LEDY	11-11-11		1)4	0819	1	11166	S X	2005
	F	30. Name and address of person	who completed cause	e of death (Item	23a) (Type,	Print)	0819		I rich	901,	2005 2005 21014 Maryland

			State of Maryland / Department State		ental Hygie	ne	
			1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg. 2. Date of Death	No.	3. Time of Death
	Physicia		Mary Frances Bova		Month	Day Year 2005	5:47 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	11ty 13 5 2	4c. County of Death	J.47 F
			4317 Drake Court	Waldorf		Charles	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	g. Birthpl Coun	ace (State or Foreign try)
	Director		203-14-2179 1 Yrs. Usual Residence of Decedent	<u> </u>	Mar. 28,	1924 Penns	ylvania
	yland		10a. State 10b. County 10c. City, Town or Lo	ocation		10	Od. Inside City Limits
	e Mar	ctor	MD Charles Waldorf				1 ☐ Yes 2X☐ No
	vith th	Funeral Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Coun	try?
	eath v	erai	4317 Drake Court  11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spec	city Yes or No-	USA 14. Race - America	an Indian
(0	r Item	Fun	1 TVNever Married 2 □ Married 1 □ Yes 2 MTNo	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	Rican, etc.)	Black, White, e	etc.
93	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show he Medical Exercities must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: Whi	te
5-0	72 h	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation  a kind of work done during most of working	16b	. Kind of Business/Ind	lustry
12	within ane. then	dmo	Elementary/Secondary (0-12)   College (1-4or 5+)	DO NOT use retired)  Cretary	Т	rucking/Un	ion
<b>d</b> 2	filled Hygir other ent, L		17. Father's Name (First, Middle, Last)	18. Mother's Name			1011
lan	uld be Aental rked tic ev	To Be	Joseph Bova	Frances	Scarpac	i	
lary	2 sho and h is me			ng Address (Street and Number or Rural			Code)
2 ₀`	l and lealth im 27 her tr			8 Watertrumpet Cour			603
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28e-f show any injury or other treumetic event, the Medical Examinat must be publised at once.		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	matory or other place)		Location - City or To	
턡	artme artme ortent injury			tion Cemetery 05-24 2. Name and Address of Facility		Tinton, MD	
B	Depa Impo any i		Mark A. Broham	Huntt Funeral Home P.O. Box 156, Wald	orf. MD	20604	
F			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	RIOR DISEASE			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			1	
b		-	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):				
	uted d ansit	Examine	cause. Litter Underlying Cause (Disease or injury				
ó	exect an and riat-tra	Exa	that initiated events resulting in death) Last				
8760,	death certificate be executed e attending physician and d for use as the buriat-transit	Physician/Medical	d				
9	n certific anding pl use as t	Med	IF FEMALE:				
Вох	attending for use a	sian	A Dregnant at time of death	□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	ry Day Year
0		nysid	1 Yes 2 No 9 Unknown				
٥,	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacc	co use contribute to the	e cause of death?
ord	w require been sk should b				1 Tes	2 No 3 Proba	ably 4 □Unknown
ecc	aw law	Completed			24a. Was an autopsy	prior to con	osy findings available appletion of cause of
Vital Records,	Thate page				performed		2 No
Z <u>i</u>	Physicien: this certific ral director,	Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	26. Place of Death	/	2 T 2 1 12 11	
of	g Phys er this eral dir	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of	of 28c. Injury at 28	8d. Describe how in	e 6 □Other (Specify, njury occurred	)
ion	Attending r death. sctor: After by the funer	atio	2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division	or Attending after death. Director: After in by the funer	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, sti building, etc. (Specify)	reet, factory, office	8f. Location (Street City or Town, S.	t and Number or Rural tate)	Route Number,
0	oltel c						
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edicai	29a. Certifier 1	n occurred at the time, date and place, ar ivestigation, in my opinion, death occurred	d at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)
	To the within 2. To the I complet	Me	29b. Signature and title oncerniler	29c. License number	29d.	Date signed (Month, L	Day, Year)
)				D42509		05/20/0	25
0	- 17		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	C	<u> </u>	and an
	NBIN		21 Date filed (Month Day Year) 22 Denistrate Signature	DLD LIME CTE	JUSTE 1	w uno	CU MJ
	Sta <del>R</del> egistr	-	MAY 2 3 2005 Seems &	barle			

ROBERT BUTLER 05-03460 RKD

			For Stete Registrer	State of	Maryland /		artment of Hotalinate of L		and Mental Hy	giene	5 18796
	Division		1. Decedent's Name (First, Middle,	ast)					2. Date of De Month	ath Day	3. Time of Death
	Physici /Medic		ROBERT RAYMOND B	UTLER, JR	•				MAY	18, 20	005 7:17P. M
	Examin		4a. Facility Name (If not institution, g				4b. City, Town, or	Location of	f Death	4c. County	
			PRINCE GEORGES H			den i melden melen a. a. h.	CHEVERLY If Under 1 Year		24 Hrs   9 Date of Bir		E GEORGES
	Funeral Director		5. Social Security Number 213–46–6249	.Sex 7. 11X M 2 □ F	. Age (In yrs. last	Yrs.	Months Days	Hours	Min. (Month, Da	th 19, Year) 2, 1944	9. Birthplace (State or Foreign Country) MARYLAND
			Usual Residence of Decedent		01				TIMONICI	2, 1744	TIAKTDAND
	ylanc		10a. State 10b. County		10c. City, To						10d. Inside City Limits
	Ba-f e	ctor	MARYLAND PRINCE	GEORGES	CAPIT	OL H	EIGHTS				XXYes 2 □ No
	्री में 0 28	Director	10e. Street and Number				10f. Zip Code	2		10g. Citizen of V	
	72 hours after death with the Maryland natural', or llams 23s or 28s-f ehow deal Exactreer qualities and lified at	ral	1512 NOVA AVENUE		lant Consin II C	10.1	2074		- 2 /Sasait Van as Na	UNITED	
	72 hours after dea "naturaf, or Itams edical Exstaller m	Funeral	11. Marital Status  1 Never Married 2 Married	Armed Ford		13. \	f Yes, specify Cubar	n, Mexican	gin? (Specify Yes or No , Puerto Rican, etc.)	Blac	e - American Indian, ck, White, etc.
36	irs aft	by	3 Widowed 4 Divorced	If Yes, Give Year or Dat			I□Yes 🛣 No	Specify:		Specify	BLACK
5-0036	2 hou		15. Decedent's	Education	1	6a. Deced	ient's Usual Occupa	tion	of working	16b. Kind of Bu	usiness/Industry
215	within 7 ene. than "n	aple.	(Specify only highest Elementary/Secondary (0-12)	College (1-4	4or 5+)		kind of work done d OO NOT use retired)	uning most	or working		
2121	filed wil Hygien other th	Completed	12TH GRADE			PAR	TS CLERK			AUTOMO	
Maryland	s 1 and 2 should be filed within 72 hc f Health and Mental Hygiene. item 27 is marked other than "natur other traumatic avant, II e Madical	Be	17. Father's Name (First, Middle, La						r's Name (First, Middle		,
yla	nould be in Mental I Mental I markad o matic ava	ဥ	ROBERT R. BUTLER  19a. Informant's Name/Relationship		1.	Ob Mailie			GERTRUDE P		
Ma	d 2 sh th and 7 is m traum		MARY BUTLER / WI							•	ARYLAND 20743
	of Health of Health item 27 i		20a. Method of Disposition	r L	20b. Place	of Dispo	sition (Name of		Date		City or Town, State
Baltimore,	permit. Pages 1 Department of H Important: if ites any injury or ott		1 XBurial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe		iaia i		natory or other place		IAY 23 2005	CLINTON	, MARYLAND
Ħ	artme ortan injur		21. Sanature of Funeral Service		1113011			<u> </u>		CHIMION	, Internation
B	permit. Departr Imports any inju		LYDIA C. THORNTON	JOHNSON M	00583	34	ORNION FUNE	Kal Hu In Roat	ME, P.A. D, INDIAN HEAI	). MARYLAN	D 20640
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that car	used the death. D				The said and the s		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ny ono oddoo on od	Athornes 60	nhi	Cardioves	enters	Dispuso		Onset and Death
	/Medical		resulting in death)	a Due to (o	r as a consequen	ce of):	Choto io i - igi	000,000	Piacos		
	Examiner		Sequentially list conditions,	b			111117 -501				
	po ##	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Sua to (a	r as a consequent	ce of):					
	be executed ician and buriat-transit	Examiner	that initiated events resulting in death) Last	c	r as a consequen	ce of):					
8760,	ate be executed hysician and the burial-transit	a E		20010 (0	. as a somosqueri	00 01).					
687	phys phys s the	dical		d							
Box (	death certific e attending pl ad for use as t	N/W	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy					23d. Dat	te of delivery
ă	death a atte	iclai	in the past 12 months?	4☐ Pregna	th 2 🗌 Fetal deant nt at time of death		Ectopic pregnancy Other (specify)			Мо	onth Day Year
0	that the death cer ed by the attendin detached for use	Physiclan/Me	9 ☐ Unknown	9∐ Unknov	NΠ						
S,	requires that the	by P	Part II. Other significant condition	s contributing to dea	ath but not resultin	g in the u	nderlying cause give	n in Part I.	23e. Did t	obacco use cont	ribute to the cause of death?
rd	w require been sig should t	ed							1	Yes 2 No	3 ☐ Probably 4 ☐Unknown
Records,	S S	Completed							24a. Was		Were autopsy findings available prior to completion of cause of
Ä	9 4 9	E O							1 X Yes	ormed?	death? 1 ☑ Yes 2 ☐ No
Vital	lysician: Th iis certificate director, pag	Be (	25. Was case referred to medical examiner?						of Death (Check only	one)	
of V	is is	2	1X Yes 2□ No			Outpatier		4   Nul	rsing Home 5 Resi		
n	ding Ph	on:	27. Manner of Death  1 ★Natural 5 ☐ Pending		Injury 28 , <i>Day Year)</i>	b. Time of Injury	Work	:?		how injury occur	red
Sic	Attanding r death. actor: After by the fune	icat	2 Accident investiga 3 Suicide 6 Could no	t be	of Injury At home	farm etc		res 2□1		Street and Numb	per or Rural Route Number,
Division	or A after Dirac in by	Certification:	4 Homicide determin		of Injury - At home g, etc. (Specify)	, rainn, su	eet, lactory, office		City or To	wn, State)	or or ribral ribato Hamber,
	Hospital 24 hours a Funaral I		29a. Certifier 1 ☐ Certifying	Physicien: To the I	est of my knowle	dge, deatl	n occurred at the tim	e, date and	d place, and due to the	cause(s) and ma	anner as stated.
	To the Hospital or Attand within 24 hours after death To the Funaral Diractor: completely filled in by the	Medical	(Check only 2 Medical Exone)	ceminer: On the bas and manne	sis of examination	and/or in	vestigation, in my op	inion, deat	th occurred at the time,	date and place,	and due to the cause(s)
	To th To th Comp	M	29b. Signature and title of certifier				29c. License	number		29d. Date signe	d (Month, Day, Year)
			Hansk Port	theul mr			OC	ME		MAY 19,2	2005
			30. Name and address of person w	no completed cause	of death (Item 23	la) (Type,					
	474		Hamela E. S	outhall, M	10		111 Pe	nn St	reet Balti	nore Mar	yland 21201
	Sta		31. Date filed (Month Pay Yeg)	) 2005 <sup>32.</sup> P	istrar's Signature	K 1	porte				
	Regist	ar		1	THE COST	7					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 40 AM BACON MAY 2005 WARNELL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BACTIMORE
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. VA MEDICAL CENTER BALTIMORE 8. Date of Birth (Month, Day, Year) August 04,1919 Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Georgia 1⊠M 2□F 85 Yrs. 258-30-4501 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State or than "natural", or items 23a or 28a-f show the Wedisul Examiner must be multiput at 1X Yes 2 □ No **Funeral Director** Laurel Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20724 3514 River Bridge Way death \ Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: Specify: Black hours after 1X Never Married 2 Married 1 ☐ Yes 2 No Specify: Maryland 21215-0036 þ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Private Railroad Worker 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be 1. Department of Health and Mental 1. Importent: If the 27 is more any injury or other. 2 should be fi and Mental h Markey Easton Clifford Bacon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3514 River Bridge Way, Laurel, MD 20724 Elease Bacon/ Sister Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville Vet. Cem. 05/23/2005 Crownsville, Maryland 4 □ Donation □ Other (Specify)
21. Signature of beneral Services 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Rd, Landover, MD Approximate Interval Between Onset and Death Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Z DAYS INFFRCTION MYOCARDIAL Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending pl IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) signed by the a Ö 9 Unknown ٦ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No SEPSIS Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed Ves 2 No has 1 Yes certificate 26. Place of Death (Check onl. one or Attending Physicien: 25. Was case referred to medical examiner? Be Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 After this 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 5 Pending 1 ☐ Yes 2 ☐ No after death.

Director: Af
d in by the ful investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Could not be 3 Suicide determined filled in by 4 | Homicide within 24 hours a To the Funeral C Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MAY 18,2005 en W. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ION, GREENE ST BACTIMORE, MD 2/201 W. MEADOWS DEAN M. D -31. Date filed (Month, Day, Year) Registrar's Signature State MAY 2 3 2005 Registrar

			1 - For State Registrar	State of Marylan	id / Depa		lealth and	d Mental Hy	giene	0.5	18798
			negistrar     Decedent's Name (First, Middle, Las	t)		tinoute or	Dealit	2. Date of De	Reg. No.	10.00	3. Time of Death
	Physici	an	CHARLES ALBERT	BAUMGARTNER				Month May	Day 13	2005	8:30 p M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of De			unty of Death	0.50 Р
	Examili	ler	6708 Kerman Court			Seabroo				nce Ge	orgo!c
	Funeral		5. Social Security Number 6. Se		last birthday)	If Under 1 Year	If Under 24 H				place (State or Foreign
	Director		173-01-7959	<sup>™ 2□ F</sup> 102	Yrs.	Months Days	Hours M	lin. (Month, Da Nov. 13	3, 1902	2 Penn	sylvania
	pu ,		Usual Residence of Decedent	10- 0	T						
	aryla shov	<u>_</u>	10a. State 10b. County		ry, Town or Lo	cation				1	0d. Inside City Limits 1   Yes 2   No
	Me M	ect	Maryland Prince C	eorge's Se	abrook	101 7: 0.1			10 000	4100 . 0	
	with t	by Funeral Director				10f. Zip Code	_			of What Cour	itry !
	eath	era	6708 Kerman Court	12. Was Decedent Ever in U	S 13.1	2070		(Specify Yes or N	U.S.A	Race - Americ	ean Indian
10	fter d	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No				(Specify Yes or No lerto Rican, etc.)		Black, White,	
980	urs a	b	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🕅 No	Specify:		Sp	<sup>ecify:</sup> Whi	ite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-1 show he Medical Examinar must be notified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation	16a. Deced	dent's Usual Occup	pation	working	16b. Kind	of Business/Inc	dustry
21	thin .	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retire	d)	norking			
21	ygien ygien t, the	ပ်	12		Roof	er				Roofi	ng
ğ	be fill d oth	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle		name)	
Z	ould Mer narke	2	Henry Baumgartner					Jane Schu			
Maryland	12 st h and 7 is n traun		19a. Informant's Name/Relationship (7	ype, Print)				Rural Route Numb			Code)
e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is merked other than "natural", or tteme 23a or 28a-1 show any injury or other traumatic event, the Medical Examinet must be notified at ance.		Evelyn L. Thume  20a. Method of Disposition	20b. F		Kerman ( sition (Name of natory or other place		Seabrook,		on - City or To	wn. State
5	ages int of t: if it		1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	nemovar nom State		natory or other pla ge Memoria	1 )	/19/2005			ssia, PA
Baltimore,	artme ortan injur	- /	21. Signature of Fune/al Service Licens					Gasch's F	_		
ä	Depa impo any is		17 Consta	nee Mas				venue, Hy			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the deat	h. Do not ent	er the mode of dyir	ng, such as card	liac or respiratory a	rrest,		Approximate Interval Between
	Pnysician	8 0	Immediate Cause (Final disease or condition	. Pneumonia							Onset and Death Weeks
	/Medical		resulting in death)	Due to (or as a conseq	uence of):						. weeks
Ь	Examiner		Sequentially list conditions	b							
	D #	lue.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):						
	and -trans	Examiner	cause. Enter Underlying that initiated events resulting in death) Last	c Due to (or as a conseq	meace of/:						
8760,	cate be executed by sicien and the burial-transit	Ical E		Dae 10 (01 as a 001354	uerice 31).						
687	death certificate be executed e attending physicien and of for use as the burral-transit			d							
Box (	eath certific attending p	/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d.	Date of delive	erv
	death e atte d for	Iclai	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		]Ectopic pregnancy ] Other (s <i>pecify)</i> _	у			Month	Day Year
Ö	by the destached	Physician/Med	9 Unknown	9□ Unknown							
S,	The law requires that the set has been signed by th bage 2 should be detache	by P	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use o	contribute to th	ne cause of death?
ord	w require been si should b	ed						_ 1_	Yes 2∭N	o 3 ☐ Prob	ably 4 □Unknown
Records,	e law r has be ne 2 sh	ple						24a. Was		prior to cor	psy findings available inpletion of cause of
		Completed						perfo 1 ☐ Yes	ormed? 2 X No	death?	2 No
Vital	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Hamitalı		04		Death (Check only o			
of	Physi this c	2	1 ☐ Yes 21X No  27. Manner of Death	1	ER/Outpatien	t 3 DOA	1er: 4 ☐ Nursino	g Home 5X Resi			/)
UC	Attanding Physician: r death. sctor: After this certific by the funeral director.	ertification:	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	Wor	rk? Yes 2 ∐ No	28d. Describe	now injury oc	currea	
Division	deat deat ctor: y the	fica	3 Suicide 6 Could not be	28e. Place of Injury - At he	ome, farm, str			28f. Location (	Street and N	ımber or Rura	I Route Number,
2	efter efter Dire	ert	4 Homicide	building, etc. (Specif	ý)	,,,		City or To			
	Hospital 14 hours e Funerei I tely filled	alc	29a. Certifier 1 M Certifying Phy (Check only 2 ☐ Medical Exam	ysician: To the best of my kno	wledge, death	occurred at the tir	me, date and pla	ace, and due to the	cause(s) and	l manner as st	ated.
	ths in 2	ledical	one)	iner: On the basis of examina and manner stated.	ition and/or inv			ccurred at the time,			
	To T	Ž	29b. Signature and title of certifier	1		29c. Licens				gned (Month,	
1	(5)		114000	uni de		D2409	93		May 1	6, 200	5
1	(2)		30. Name and address of person who of Mark Parkhurst, N				verdale	, Marylan	d 2073	7	
	Sta	ite	31. Date filed (Month, Day, Year)	732. Registrar's Signa	ature		· CIUUIC	, imijian	4 2013		
	Registr		MAY 2. 0 2005	Alexan &	Spare						

		1 - For State Registrar	State of Ma	*		nt of H	ealth and	-		e 2005	19790
		Decedent's Name (First, Middle, Last,	}			07 2		2. Date of D			3. Time of Death
Phys	ician	Lillian Virgini						Month	_ D	ay Yea	
	dical				11.00	~		May	-	0005	0605 "
Exam	niner	4a. Facility Name (If not institution, give			4b. Cit	y, Iown, or	Location of Dea	ath U	4	c. County of De	
7		Peninsula Legion		al Cente	<u> </u>	Sali-	If Under 24 H			Wicon	nico
Funer		5. Social Security Number 6. Sec	TM 2FDF	(In yrs. last birthd	Month	er 1 Year s Days	Hours Mi	n. (Month, D	irth <i>ay,</i> Yea	r) 9. B	irthplace (State or Foreign Country)
Directo	or	213-42-0410	7	8 Yrs	-			3/14/1	1927	Ma:	ryland
U B'		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	r Location						10d. Inside City Limits
A show	_			Salisb							1 ☐ Yes 2 ☑ No
M e M	ctc	Maryland Wicomic	,0	Sallsbu							
W # 22 3	Director	10e. Street and Number			10f. 2	Zip Code			10g. C	itizen of What (	Country?
1215-0036 within 72 hours after death with the Maryland one. The metal record of the maryland one metal record one in the maryland of the maryland of the market of the ma	<u>ia</u>	309 Wyman Drive			2	21804				USA	
A de	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Dec	edent of His	spanic Origin?	(Specify Yes or N arto Rican, etc.)	10-	14. Race - An Black, Wh	
1036 Ours after of Endit or Item	正	1 Never Married 2 Married	1 ∐Yes 2 <b>X</b> N If Yes, Give	lo		2 🔀 No					white
21215-0036 dwithin 72 hours aft gigner. Then "neturel", or the "neturel", or th	d by	3X Widowed 4 □ Divorced	Year or Dates:							Opcomy.	WIIICE
72 h	ete	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>	16a. De	ecedent's Us	sual Occupa	ition fu <i>ring</i> most of w )	rorking	16b.	Kind of Busines	s/Industry
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d 21 d 21 Hygier th	Completed	7	_	Hor	nemake	1			1	Domest.	ic
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aryland 212 should be filed with not Mehoral Hygiene, marked other the unestic event, that	ဥ	Norwood Tull					OTIVIA	Marshal			
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Marylar of Heams 19 piene. The marked other then "neturel", or items 23e or 28e-f show other treumetic event. I've Marifael Exam for normal technifical.		19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. M	ailing Addre	ss (Street a	and Number or i	Rural Route Num.	ber, City	or Town, State	Zip Code)
J N and Salth or tr		Caleb Jones/son					Lane,	Salisbur	у, 1	4D 2180	1
Baltimore, Moemit. Pages 1 and: Department of Health Importent: If item 27 eny injury or other tr		20a. Method of Disposition	Name and forces Chate	20b. Place of Di cemetery,	sposition (Normatory of	lame of r other place	9)	Date	20c. l	Location - City of	or Town, State
Bage Page nort: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Cremation 2 ☐ Cremation 3 ☐ F	intombment	Wicomic	o Men	orial	unk	nown	Sa	alisbur	y, MD
altim mit. Pa partmen cortent:	ej	21. Signature of Funeral Service Lice				and Addres	s of Facility		_		Association
Balt permit. Departiment import	OUCE	West R	rue, (	FSP	HOLLO	way F	uneral	Home Pro , Salish	otess	sional A	Association
_		23a. Part1. Enter the disease, or compl	ications that caused	the death. Do not						210	Approximate
		shock, or heart failure. List only of Immediate Cause (Final			. 1	$\mathcal{L}$		V			Interval Between Onset and Death
Physicia /Medica		disease or condition resulting in death)	Cons		- N	oins	4	Wen	1		
Examine	÷ .		Due to (or as a	a consequence of):							
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led	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	520 10 (0. 45 )								
<b>livision of Vital Records, P.O. Box 68760,</b> or <b>Attending Physicien</b> : The law requires that the death certificate be executed titer death. Director: After this certificate has been signed by the attending physician and in by the tuneral director, page 2 should be detached for use as the burial-transit	xan	that initiated events resulting in death) Last	Due to (or as a	a consequence of):							
760, te be ex ysician	caiE										
87 icate physis			d								
Box 68  Beath certifice attending ph	₩e	IF FEMALE:	12a If was autooms	-f							
BO ath c	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth	2 Fetal death	3 Ectopic				- 4	23d. Date of d Month	elivery Day Year
o. O. In the de by the a tached f	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at: 9☐ Unknown	time of death	5 Other (	specify)					•
P.O. Box 68 that the death certificated by the attending predeted for use as the	Physician/Med							00- Did	A=b====		to the cause of death?
S, F res tha igned be de		Part II. Other significant conditions con	ntributing to death bu	it not resulting in th	e undenying	g cause give	in in Part I.				
Cord  * requir  been si	te	1). Osetts me	((1 40					. 1	Yes 2	2 LINO 3 LJ	Probably 4 Dunknown
Rec( le law r has be	pie	Reval tank	und					24a. Wa	s an	24b. Were	autopsy findings available completion of cause of
The The page	Completed by								formed?	death?	
Division of Vital Records, to Attending Physicien: The law requires that deter death.  Director: Attent this certificate has been signed in by the funeral director, page 2 should be or	O)	25. Was case referred to medical					26. Place of D	eath (Check only			
f Vita ysicien: is certific director,	0 8	examiner?	lospital: 1 Inpatier	nt 2 ☐ ER/Outpa	tient 3 🗆 I	Othe	r: 4 🗆 Nursing	Home 5 ☐ Res	sidence	6 □Other (Sc	ecify)
g Physer this eral dii	H	27. Manner of Death	28a. Date of Injur (Month, Day		e of	28c. Injury Work		28d. Describe			
ion ording Marker : After	엹	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Inju	M		r ∕es 2 □No				
Divisio	Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ıry - At home, farm,	street, fact	ory, office		28f. Location	(Street a	ind Number or I	Rural Route Number,
Div after Direct	ert	4 Homicide	building, etc	:. (Specify)				City or To	own, Sta	fe)	
spite ours nerel	ai C	29a. Certifier 1 Certifying Phy	sicien: To the best o	of my knowledge, d	eath occurre	ed at the tim	e, date and pla	ce, and due to the	e cause(	s) and manner a	as stated.
To the Hospitel owithin 24 hours at To the Funerel D completely filled i	edicai	(Check only 2 Medicel Exami	ner: On the basis of and manner sta	examination and/o	r investigati	on, in my op	pinion, death oc	curred at the time	, date ar	nd place, and di	ue to the cause(s)
o th o thin ompl	₹	29b. Signature and itle of certifien			2	9c. License	number		29d. D	ate signed (Mor	nth, Day, Year)
F S F S	0	1 the work			C	>002	J676	1	2	10121	
- 4	3	30. Name and address of person who co	ompleted cause of de	ath (Item 22a) /T							
6	12	30. Name and address of person who co	Minimpleted cause of de	() (1y	0:2:0	ion	sty :	Pelisbu	44	nd	61804
	State	31. Date filed (Month, Day, Year)		r's Signature			,	- • •	,,		·
	strar	MAY 2 0 2		- K	Rosel						

			For State Registrar			State			d / Depa		t of H	ealth a		lental Hy	giene	201	35	10000
			Registrar     Decedent's Name	(First, Middi	e, Last)					ramour	0 0, 2	Jean		2. Date of De	Reg. No.	. 0 !	2 1	3. Time of Death
	Physicia		STANLEY			BARRE	TT							May 14	, 200		Year	7:30 A M
	/Medic Examin		4a. Facility Name (If	not institution	n, give s	street and n	ımbər)			4b. City,	Town, or	Location of		114) 11			of Death	
	LAGITIII	Ç.	Shady Gr	ove Ad	ven	tist H	osp:	ital		Roc	kvil	le			Mo	onte	omei	CV.
	Funeral		5. Social Security Nu		6. Sex	(			last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da March			9. Birth	place (State or Foreign
	Director		118-09-8		11	M 2□F		89	Yrs.	Nontrio	Days	110013		March	14,19	916	New	York
	pug *	}	Usual Residence of I	10b. County	,		1	10c. Cit	y, Town or Lo	ocation							-	10d. Inside City Limits
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	28a-1	ect	Md •	Monte	,ome	ГУ		Ga	ithers	10f. Zip	Code				10g. Citi	zen of V	Vhat Co.	intry?
	with Ba or	<u> </u>	101 Oden		ve.	#1009	,				2087	7			-		Stat	•
	me 2:	Funeral Director	11. Marital Status			12. Was Dec	edent E	ver in U	.S. 13.	Was Deced	dent of Hi	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		14. Rac	e - Amer	ican Indian,
9	or ite	큔	1 Never Marrie	od 2□ Mar	ried	Armed F 1 ☑ Yes If Yes, G	2 🗆 N					n, mexicar Specify:	i, Pueno	HICAN, etc.)			k, White	
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5-	natu	ete		15. Deceder fy only highe			)		(Give	dent's Usua kind of wo	rk done d	luring mos	t of worki	ing	16b. Ki	nd of Bu	ısiness/l	ndustry
12	within 72 hours after death with the Maryland ene. then "naturel", or iteme 23a or 28a-f show then Marical Examilian maat ke notified at	Completed	Elementary/Secon	ndary (0-12)		College 3	(1-4or 5-	+)	Engin	<i>DO NOT</i> us <b>eerin</b>			ist		Engi	inee	ring	r
d 2	filed Hygie other		17. Father's Name (/	First, Middle,	Last)						0 -F			(First, Middle				
Maryland 21215-0036	lid be lental rked c	To Be	Reuben Ba	arrett								Dina	ih St	een				
ary	shou and M s mar		19a. Informant's Na	me/Relations	ship (Ty	pe, Print)			19b. Maili	ng Address	(Street a	and Numbe	er or Rura	al Route Numb	er, City of	r Town,	State, Z	ip Code)
Z	and 2 palth a 27 is er tre		Charles 1	U. Bar	ret	t (Son	.)		_				l Mi	ddleto	wn, l	1d.	2176	59
ore	of He		20a. Method of Disposition 1   Burial 2   □		3 □B	lemoval from	State	20b. F	Place of Dispo emetery, crea	osition (Nar matory or o	ne of ther place	θ) ]	May :	)ate 19.	20c. Lo	cation -	City or 1	Town, State
Ë	Page ment o ant: If lury or		` 4 ☐ Donation				· Otato	Qua	ntico			ļ	200		Qua	ntio	00,	Va.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene important: If item 27 is marked other then "naturel", or iteme 23a or 28a-f show any injury or other treumatic event, the Medical Examinating must be notified at once.		21. Signature of Fur	neral Service	License	Des				2. Name an O Eas			De.	Vol Fun Or. Gai				Id. 20877
			23a. Part1. Enter th shock, or hear	e disease, o	r compli	ications that	caused each lin	the deat	h. Do not en	ter the mod	e of dying	g, such as	cardiac c	or respiratory a	rrest,			Approximate Interval Between
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68760,	death certificate be executed e attending physician and ad for use as the burial-transit	icai				Rena	1 Ir	suf	ficenc	у								
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Вох	death certifica attending ph d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent		2	3c. If yes, or		of pregna		∃Ectopic pr	egnancy				2		e of deliv	
	tt the dea by the att	sici	in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown				nant at	time of d		Other (sp						Moi	ntn	Day Year
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co.		e Co	25. Was case referre	ad to modice								OC Disease	-4 D4h	1 Yes	2 No	1	Yes	2 No
Vital	Physiclen: r this certific ral director,	o B	examiner?			lospital:	Inpatier	nt 2 🗆	ER/Outpatier	nt 3 DC	Othe			n <i>(Ch</i> ec <i>k only c</i> me 5□ Resi		: Oth	or /Soac	(64)
of	g Phy er this	<u>-</u>	27. Manner of Death	i i	- 1	28a. Date		y	28b. Time o		8c. Injury Work	at		28d. Describe				7
jo	Attending I death. ctor: After y the funer	atio	<ol> <li>XNatural</li> <li>Accident</li> </ol>	5 Pendi invest	ng igation	(///	пп, Бау	1641)	injury	М		res 2 🗀	No					
Division	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Certification	3 🗌 Suicide 4 🗍 Homicide	6 Could determ		28e. Plac	e of Inju ling, etc	ry - At he . (Specif	ome, farm, str	reet, factory	, office			28f. Location (: City or Tox	Street and vn, State,	d Numb	e <i>r or R</i> ui	ral Route Number,
	Hospitel Punerel Funerel Itely filled	ai Ce	29a. Certifier	1 Gartifvi	na Phys	sician: To th	e best o	f my kno	wledge deat	h occurred	at the tim	e date an	d place	and due to the	causa(s)	and ma	nner as	stated
	he Hos he Fun hetely	ledicai		2 Medical	Exami	ner: On the and ma	basis of	examina	ition and/or in	vestigation	in my op	pinion, dea	th occurr	ed at the time,	date and	place, a	and due	to the cause(s)
	To the within 2 To the comple	Ž	29b. Signature and I	title of certifie	or .	00	15	1		290	. License	number			29d. Date	e signed	(Month	, Day, Year)
	541		Kath	Mu V	m li	elte	he C	Lan		h	1 6	607	13.		Ma	ıy 1	4, 2	.005
	) · ( ·		30. Name and address	leen M	cSha	ane M.				Print)				ckville	∍, Mċ	1. 2	0850	
	Sta Registr	_	31. Date filed (Monte	h, Day, Year Y 19	200	5	Registra	r's Signa	ature /pe	de								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 17 2005 8:44 A BLACKSTONE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY SUBURBAN HOSPITAL BETHESDA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 28, 15 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1∏ M 2□ F Yrs. 101 1903 New Jersey Director 578-36-2387 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in their "natural", or Itams 23e or 28e-f show the Medical Examinat must be rediffed at 1√Yes 2□No Directo Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20814 5721 Grosvenor Lane United States 2 should be filed within 72 hours after death and Mental Hygiene.
Is marked other than "natural", or Itams 23 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 Divorced Specify white 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Retail Sporting Goods Merchant other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health, and Mental Hy Importent: If Item 27 is marked oth any injury or other treumatic event page. Be Molly Smokler Sam Schwartzberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joseph A. Baldinger, Power of Attorney, 5405 Audubon Road, Bethesda, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Washington Hebrewelong. 1 X Burial 2 ☐ Cremation 3 X Removal from State b \* 4 ☐ Donation 5 ☐ Other (Specify) May 19, 2005 Washington, D.C. Memorial Park 21. Signature of Funeral Service Licensee Danzansky-Goldberg Memorial Chapels, Inc. Donald 1170 Rockville Pike, Rockville, ND 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MYOCARDIAL INFARCTION SUDDEN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ATRIAL FIBRILLATION Sequentially list conditions, any, reading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed use as the burial-transi the attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 Yes 2√ No Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 🔀 EP/Outpatient 3 ☐ DOA Other: 2 1 ☐ Yes 2X No 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident efter death Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerel C 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

18

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

 $\mathcal{M}$ 

2309 SHOREFIELD ROAD, WHEATON, MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

DAPHNA HENKIN, M.D.,

D0053528

MAY 18, 2005

20902

		State of Maryland / Department of Health and 1- State Amend Item 24a per Verb., G844-06-05-dbb ath		
Physicia /Medic	al	Decedent's Name (First, Middle, Last)     Eleanor Catherine Boyer  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Dea	2. Date of Death May 26,	2005 Year 3. Time of Death 1:22 PM <sub>M</sub>
Examin Funeral	ier	Northampton Manor Health Care Center Frederick  5 Social Security Number 6 Sex 7 Age (In vrs. last birthday) If Under 1 Year If Under 24 Hr	rs. 8. Date of Birth (Month, Day, Y	Frederick  9. Birthplace (State or Foreign Country)
Director		215-20-9175	Jan. 16,	1910 Maryland  10d. Inside City Limits
28a-f sh	Director	Maryland Frederick Frederick  10e. Street and Number 10f. Zip Code	100	1 ☐ Yes 2 No
23a or		5718 Box Elder Court 21703	109	U.S.A.
natural', or Itame 23a or 28a-f show digal Examinar must be notified at	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, specify:  1 Yes 2 No I Yes 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
then to Me	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)  Cafeteria Manager	orking 16	Sb. Kind of Business/Industry  Public School
ind Mental Hygie s marked other umatic event, II	To Be Co	17. Father's Name (First, Middle, Last)  18. Mother's Name	ame (First, Middle, Ma ry Fisher	
lealth and Mental im 27 is marked har traumatic ev		19a. Informant's Name/Relationship (Type, Print)  Mrs. Janet E. King, Daughter  19b. Mailing Address (Street and Number or R. 2371 Bear Den Road,	Frederick,	
Department of Healt Important: If Itam 2 any injury or othar once.			., 2005	Frederick, Maryland
Departr Importe any inj		21. Signature of Funeral Service Licenses  Ruchan E M00255  22. Name and Address of Facility Keeney and Basfo 106 East Church S  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi	rd PA Fune t., Freder	ral Home ick, MD 21701
Medical wand physician and sthe burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, isating to innite diata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	injas	Onset and Death
the attending thed for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
sign d be	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
ate has page 2	Completed		24a. Was an autopsy performe 1 \( \text{Yes} \) 2 \( \text{L}	24b. Were autopsy findings available prior to completion of cause of death?  You 1 Yes 2 No
nis certific director,	o Be	examiner? Hospital:	eath (Check only one) Home 5 Resident	ce 6 ☐Other (Specify)
ath. or: After th	Certification; T	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident 3 Suicide 4 Homicide 4 Homicide 5 Section 1 Section 1 Section 1 Section 2 Section 1 Section 2 Section 2 Section 2 Section 3 Section 2 Section 3 S	28f. Location (Stree City or Town,	et and Number or Rural Route Number,
within 24 hours after de To the Funaral Diracto completely filled in by th	ledical Cer	29a. Certifier (Check only (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death oc		
within 24 To the F complete	Med	29b. Signature and little of certifier  29c. License number  29c. License number		I. Date signed (Month, Day, Year)
ID		30. Name and ad less of by for who completed cause of death (Item 23a) (Type Print)  Bol Toll House HW Frederick MM 2) =  31. Date filed (Month, Day, Year)  32. Registrar's Signature  JUN 0 6 2005	101. SA	JAD A212, ME
Sta Registr		31. Date filed (Month, Day, Year)  JUN 0 6 2005		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 10d per fh 8844 6-5-05 vt

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1:45P M 28, MAY 2005 LEONA ELIZABETH BRIDGES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FROSTBURG VILLAGE NURSING HOME FROSTBURG ALLEGANY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | DEC 25 1910 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 1 □ M 2X F MARYLÁND Director 216 22 6830 94 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits oriant; וז item 27 is marked other than "natural", or Items 23a or 28a-1 show injury or other traumatic event, ווא Madical Exercises המחלו אין 10a, State 10b. County 1 Yes 2 No Directo MARYLAND ALLEGANY MT. SAVAGE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 14103 MT. SAVAGE ROAD 21545 U.S. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ZX No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itel any injury or other fraumatic event, the Madical Exerciti 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes XXNo Specify: ģ 3√ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 10 HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ALTA LOWERY WALTER FRANKLIN BLANK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) EDWARD H. BRIDGES, JR. / SON 14103 MT. SAVAGE ROAD, MT. SAVAGE 21545 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition RESTLAWN MEMORIAL GARDENS 5/31/05 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) LaVALE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 60 W. MAIN STREET SOWERS FUNERAL HOME, P.A. FROSTBURG, MD 21532 M0054 Sowers. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Bilateral Immediate Cause (Final neumoma **Physician** Weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) the attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? for Month Day Year 5 ☐ Other (specify) rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28d. Describe how injury occurred After Injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D14464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L. SANDHIR, M.D., 48 TARN TERRACE, FROSTBURG, MD 21532 JUN 0 6 32. Registrar's Signature 31 Date filed (Month State Registrar

			1 - For State Registrar	State of Maryland		artment of H rtificate of L			Reg. No.	1111	18804
	Physicia	20	1. Decedent's Name (First, Middle, Last)					2. Date of De	Day	_ Year	
	/Medic			nnon				May 15			10:01 A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give st			4b. City, Town, or	Location of Death	1		County of Dea	
			Washington Advent:		ot hirthday)	Takoma If Under 1 Year	Park If Under 24 Hrs.	9 Date of Bir	Mo th	ntgome	ry
	Funeral		5. Social Security Number 6. Sex 1 1	7. Age (In yrs. la M 245xF 50	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da June 17	ay, Year)	(	rthplace (State or Foreign country) orence SC
	Director		Usual Residence of Decedent					pulle 17	, 10	74 11	orence sc
	/land		10a, State 10b. County	10c. City,	Town or Lo	ocation					10d. Inside City Limits
	Man F-f-sh	tor	MD Prince Geo	orge's Mt.	. Rair	nier					1. Yes 2 □ No
	r 28g	irec	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What C	Country?
	death with the Maryland ms 23a or 28a-f show	by Funeral Director	2905 Queens Chap	e1 Rd #1		20712			Unit	ed Sta	tes
	dea ems	ner	11. Marital Status	2. Was Decedent Ever in U.S Armed Forces?	13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S n. Mexican, Puert	pecify Yes or No o Rican, etc.)	0~	14. Race - Am Black, Wh	
õ	or It	y Fu	1 ⊠ Never Married 2 ☐ Married	1 ☐ Yes 2 X No If Yes, Give		1□Yes 2⊠ No	Specify:			Specify: B	
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7	within then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Cook		,		Pr	ivate	
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yland	d be ental ked c	To Be	Nathaniel Cannon				Margare	t McFa			
	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.  If the all the arked other then "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanting trait he rediffed at	-	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Maili	ng Address (Street a	and Number or Ru	ıral Route Numb	er, City o	r Town, State,	Zip Code)
Z Z	and 2 alth a 127 ls		Brian Cannon / Son		864	Spring Ci	rc1e #10	1 Deerf	ield	Beach	Florida
e G	of He of He ritem		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	CO CO	metery, cre.	osition (Name of matory or other place		Date	20c. Lo	cation - City o	r Town, State
Ĕ	permit. Pages 1 Department of H Important: If ite any injury or ot once.		`4 □Donation 5 □Other (Specify)	Ft.		oln Cemet				lensbur	g MD
baltimore,	ppartr ports ny inj		21. Signature of Funeral Service License	0		2. Name and Addres					
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			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	e cause on each line.	_	ter the mode of dyin	g, such as cardiad	or respiratory a	arrest,		Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	Yneun	WY	na					2 weeks
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):		100:	41.			7,100 2
		100	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to lot as a consequ	ence of):	num	o will	eucy			Tyears
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,	execu n and ial-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequ	ence of):						
9	certificate be executed rding physician and use as the burial-transit	cai	L d.			<u> </u>					
Q	leath certificat attending phy I for use as th										
X D D	h cer endir r use	J.	23b. was decedent pregnant	lc. If yes, outcome of pregnar		Ectopic pregnancy			1	23d. Date of d	
	0 0 0	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de 9☐ Unknown		Other (specify)				Month	Day Year
r Ö	that the de led by the a detached f	Physician/Med	9 Unknown		lain n in alan .		an in Daniel	22a Did	tohoooo	en contributa	to the cause of death?
ر ک	96	by	Part II. Other significant conditions conf	MADALLAC	CA A	Inderlying cause giv	en in Part I.	. 3.			Probably 4 Dunknown
ecords,	v require been si should I	Completed	Gio oue van	e come	Cocv	Charley	opern	9		_	
ပ္	e law has b	npje						24a. Was		prior to death?	autopsy findings available completion of cause of
	sicien: The law certificate has b irector, page 2 s							1 ☐ Yes	2 ANO	1 □ Ye	
Vital	Physicien: r this certific ral director,	o Be	25. Was case referred to medical examiner?	ospital:	-D/O: 44:-	ct all post Cth	er: 4 Delivering	ath <i>(Check only</i> Iome 5□Res		e Dother (C-	
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DIVISION OF	Attending or death. ector: Atterby the funer	iffeg	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor	me, farm, st	reet, factory, office		28f. Location	(Street an	d Number or I	Rural Route Number,
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	he Hospital or Attendir n 24 hours after death. he Funere! Director: A pletely filled in by the fu		29a. Certifier 1 Certifying Phys	ician: To the best of my know er: On the basis of examinat	vledge, dea	th occurred at the tir	ne, date and place	e, and due to the	cause(s)	and manner	as stated.
	To the Hospital or within 24 hours afte To the Funere! Dir completely filled in	Medicai	one)	and manner stated.				1			
	To the within To the	2	29b. Signature and title of certifier			29c. Licens				le signed (Moi	nth, Day, Year)
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-	( b)		30. Name and address of person who con				10 TV -	(af)a 18 <del>5</del> 4 D 9	22/2	1110	HOMA PARK UX
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	Sta Regist	ate rar	MAY 2 3 2005	32 Registrar's Signat	4	and it					

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	, Dharaini	13	1. Decedent's Name (First, Middle,	Last)						2. Date of Dea Month	ath Day	Year	3. Time of Death
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	land ow		10a. State 10b. County		10c. City, Town or Lo	ocation							10d. Inside City Limits
	Many If sh	tor	MARYLAND MONTG	OMERY	SILVER S	PRING							<b>MX</b> Yes 2 □ No
	n the	Director	10e. Street and Number	<u> </u>		10f. Zip (	Code				10g. Citizen of \	What Cou	ntry?
	th wil	ai D	2918 FAIRLAND RO	AD				20904	+		UNITE	ED ST	ATES
	items	Funerai	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S. 13.	Was Decede	ent of Hi fy Cuba	spanic Ori n, Mexicar	gin? (Sp 1, Puerto	ecify Yes or No- Rican, etc.)	14. Rac Blac	ce - Americk, White,	can Indian, etc.
36	s afte	by Ft	1 ☐ Never Married XXMarrie 3 ☐ Widowed 4 ☐ Divorced	1XXYes 2 If Yes, Give Year or Date		1 □ Yes 2	<b>CX</b> No	Specify:			Specify	v: BLA	.CK
9	72 hours after death with the Maryland natural; or items 23s or 28s-f show Jical Examine must be notitied at		15. Decedent's		16a, Dece	dent's Usual	Occupa	ation		1	16b. Kind of B	usiness/In	dustry
215	within 72 ene. than "ne the Medit	plet	(Specify only highest Elementary/Secondary (0-12)		(Give	kind of work DO NOT use	done a	turina mos	t of work	ing			•
21215-0036	e filed within al Hygiene. I other than vent, Iba we	Completed	Clementary/Secondary (0-12)	4 YR		PENTE	R /	UPHOI	LSTE	RER	FEDI	ERAL	GOVERNMENT
	be filed within 72 hours after death with the Marylar tal Hygiene. ad other than "natural", or items 23s or 28s-1 show event, the Medical Examiner must be notified at	Be (	17. Father's Name (First, Middle, La	st)				18. Mothe	er's Nam	e (First, Middle,	Maiden Suman	ne)	
<u>ya</u>	2 should be t and Mental I is marked of aumatic eve	င္	WALTER CALLAHAN							DE GEE			
Maryland	s 1 and 2 should I Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationshi							ral Route Numbe			
	os 1 and of Health item 27 other tr		IZZETTA CALLAHAN  20a. Method of Disposition	/ WIFE	20b. Place of Dispo	FAIRLA osition (Name	e of			ILVER SI Date	20c. Location		
Baltimore,	000		XXBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			-			M A 37	21 2005	TAIIDI	ET M	m
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*	/Medical Examiner		resulting in death)	- u.	as a consequence of):								
в	LAGITHIE	Ļ	Sequentially list conditions,	b. — Due to lor	as a consequence of			-					
	ted	nine	cause. Enter Underlying Cause (Disease or injury	Day to for	as a consequence of								
,	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequence of):								
8760,	death certificate be executed e attending physician and kd for use as the burial-transit	Icai		d									
9	tificat ng phy as th												
Вох	death certifica attending ph d for use as th	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco		⊒Ectopic pre	gnancy				1	ite of deliv	ery Day Year
O. E	ne dea the at hed fo	Physiclan/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnar 9☐ Unknow		Other (spe	city)				1910	21101	Day
Ρ.	tac pà	Phy	Part II. Other significant condition	s contributing to dea	th but not resulting in the u	underlying ca	use aive	en in Part I		23e. Did to	obacco use cont	tribute to t	he cause of death?
Records,	uires tha signed d be de	d by		g		,	3			1 🗆 Y	res 2□No	3 🗆 Prol	pably XX Unknown
Sor	w requir been si should	lete								24a. Was	an 24b.	Were auto	opsy findings available
Re	The lav	Completed								autop	rmed?	prior to co death?	mpletion of cause of
Vital		e e	25. Was case referred to medical					26. Place	of Deat	1 ☐ Yes	7111	1 🗆 Yes	2   NO
	Q 50	To B	examiner? 1 ☐ Yes 2€XNo	Hospital: 1 ☐ Inp	patient 2 ER/Outpatie	nt 3 DO/	A Othe	er: 4 🗆 Nu	ursing Ho	ome XXResid	dence 6 Oth	ner (Specii	(5/)
n of			27. Manner of Death 1XXNatural 5 ☐ Pending	28a. Date of (Month,	Injury 28b. Time of Injury	of 28	Bc. Injury Work			28d. Describe h			
Sio	Attending ir death. ector: Aftei by the fune	catle	2 Accident investiga 3 Suicide 6 Could no	t bo		М		Yes 2	No				
Division	i gitte	Certification:	4 Homicide determin	280. Flace 0	f Injury - At home, farm, st , etc. (Specify)	reet, factory,	office			City or Tow		ber or Hun	al Route Number,
	Hospital		29a. Certifier XXCertifying	Physician: To the h	est of my knowledge, dea	th occurred a	t the tim	ne. date ar	nd place.	and due to the	cause(s) and ma	anner as s	stated.
		edical	(Check only 2 Medical E	caminer: On the bas and manne	is of examination and/or in	vestigation,	in my or	pinion, dea	th occur	red at the time,	date and place,	and due t	o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	~		29c.	License	e number			29d. Date signe	d (Month,	Day, Year)
			* Conces	Jun	UMD		Γ	0952	6		MAY 20	0, 20	05
2	(12)		30. Name and address of person w	ho completed cause	of death (Item 23a) (Type	Print)							571
	Ü		FRANCIS BRUNO,			LITT	LE F	PATUX	ENT	PKWY. CO	OLUMBIA	, MD	
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 2 3 20	INS Reg	gistrar's Signature								
	negisti	ul .	mal S J C	- July	W AT HIS								

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month **Physician** May 13, 2005 8:36 P.M Feddie A. Johnson Smith Coleman /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdav) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours Min 1 □ M 2 🔀 F Yrs. March 19,1919 South Carolina 155-34-7011 86 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a. State or 28e-f show the Medical Examiner must be notified at 1X Yes 2 ☐ No Director Passaic New Jersey Paterson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 239 281 - 19th Avenue 07504 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "netural", or items 11. Marital Status within 72 hours after 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Worker Domestic 12th grade permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Importent: If Item 27 is marked other t any injury or other treumetic event, ID 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Johnson Mary Winningham 19a. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annie Bell Smith Barton 7619 - 9th Street, N.W.; Washington, D. C. 20012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ♣Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State Fort Lincoln Cemetery May 21,2005 Brentwood, Maryland 4 □ Donation 5 □ Other (Specify) 2. Name and Address of Facility R. N. Horton Co. 21. Signature of Funeral South Licensee R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Acute Myocardial Infarction /Medical Due to (or as a consequence of): **Examiner** Arteriosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of, Examine physicien and the burial-transit death certificate be executed Due to (or as a consequence of) P.O. Box 68760 Physiclan/Medical as ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 🛣 No 5 Other (specify) 4□Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, ate has been sign page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? res 20 No 1 Yes 2 No Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death injury at Work? Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel of within 24 hours a To the Funerel C 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific 13/2005 D24348 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Grufferman, M.D.; 1500 Forest Glen Road; Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) State MAY 2 0 2005 Registrar

Please Type or Print in	Black Indelible Ink.	Ensure All Co	pies Are Legible

			State of Maryland						_		egibic.	
			1 - State Registrar		rtificate					eg. No	nne	10007
	Dhorisi		Decedent's Name (First, Middle, Last)						2. Date of Dea	th Day	Year	3. Time of Death
	Physicia /Medic		Jacqueline Dunbar							16,	2005	1:38P M
	Examin	er	4a. Facility Name (If not institution, give street and number)				Location of	f Death	/		ounty of Deat	
	Funeral		Doctor's Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. las	t birthday)	If Under		If Under 2		8. Date of Birth		ince G	hplace (State or Foreign untry)
ш	Director		261-02-3280 1□ M 2⊠ F 56	Yrs.	Months	Days	Hours	Min.	July 28	194	8 Nort	th Carolina
	and *		Usual Residence of Decedent  10a. State 10b. County 10c. City, 7	Fown or Lo	cation							10d. Inside City Limits
	Maryla f sho	or		anham								1∰Yes 2□No
	r 28a-	rect	MD   Prince George's   La  10e. Street and Number	amam	10f. Zip	Code	<u> </u>		1	0g. Citize	en of What Co	untry?
	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "naturel", or terms 23a or 28a-f show event, I'm Medical Eranin et must ken celified st	Funeral Director	5804 Lundy Drive		207	706				U.	S.A.	
	r dea	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Deced	lent of Hi	spanic Orig n, Mexican,	in? (Spe , Puerto l	cify Yes or No- Rican, etc.)	14	4. Race - Ame Black, White	
36	s afte	by Ft	1 ☐ Yes 2 🖾 No If Yes, Give 3 ☐ Widowed 4 ☑ Divorced		1 ☐ Yes 2		Specify:			8	Specify: D.1	_ 1
215-0036	2 hour		15. Decedent's Education	16a. Deced	dent's Usua	ıl Occupa	ation			16b. Kind	D.I. d of Business/	.ack Industry
212	hin 72 an "na Madi	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. I	kind of wor DO NOT us	rk done d se retired	furing most	of workii	ng			
21	ygien ygien t, I'v	Completed	12th	Mana	agemei	nt An	nalyst				vernmen	t
and		Be	17. Father's Name (First, Middle, Last)						(First, Middle, I Adams	Maiden S	lumame)	
Maryland 21	should be and Menta marked umatic ev	2	John Rhodes  19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	na Address	(Street a			l Route Number	. City or	Town, State, Z	(ip Code)
	. m or 2				_				n, Maryl			
Je,	of Health of Health if item 27 I		20a. Method of Disposition 20b. Plac	e of Dispo	sition (Nan	ne of ther place	e)	D	ate	20c. Loc	ation - City or	Town, State
Ē	Pages ment of ent: If it ury or o						et. 5,	/24/	05	Clint	ton,Mar	yland
Baltimore,	permit. Pages Department of Importent: If it any injury or c		21. Signature of Foresal Service Literature				s of Facility	J.	B. Jenl			
	<u></u>		23a. Part 1 Solar Pe disease, or semplications that caused the death.						Landove		iarylan	d 20785 Approximate
			shock, or heart failure. List only one cause on each line.				_	ardiac o	r respiratory arr	est,		Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of the conse	nce of):	lmoi	cory	6	2110	rpsi			Minutes
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	and I-trans	Examiner		nce of):				(A	Rcino	ma		No.
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9	ifficate g phy: as the											
Box	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal de		]Ectopic pr	egnancy				23	3d. Date of deli	•
	e deal	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  in the past 12 months? 4 ☐ Pregnant at time of deat 9 ☐ Unknown		Other (sp						Month	Day Year
P.0	res that the de signed by the a be detached f	Phy	Part II. Other significant conditions contributing to death but not resulti	na in the u	nderlying c	ausa dive	en in Part I.		23e. Did to	bacco us	e contribute to	the cause of death?
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	The fa te has	Completed	Service Surface						autops perfori	med?	death?	completion of cause of
Vita	ien: artifica ctor, p	BeC	25. Was case referred to medical examiner?					of Death	(Check only on	-		
	hyslo this ce al dire	မ	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ EF				4 🗆 Nur	_	ne 5 Reside			cify)
UC C	Jing F	lon	1 Natural 5 ☐ Pending (Month, Day Year)	Bb. Time of Injury	M 2	8c. Injury Work	rat ⟨? Yes 2 □ N		28d. Describe ho	ow injury	occurred	
Division of	death death ctor: y the	fical	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home	e, farm, str							Number or Ru	ral Route Number,
á	el or safter	Certification:	4 ☐ Homicide determined building, etc. (Specify)						City or Town	n, State)		
	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier (Check only (Ch	edge, deatl	h occurred	at the tim	ne, date and	d place, a	and due to the c	ause(s) a ate and p	nd manner as	stated. to the cause(s)
	To the hwithin 24	Medical	one) and manner stated.  29b. Signature and title of certifier				number				signed (Month	
	Z × Z		16 Mila Ota				528	65				12005
)	0		30. Name and address of person who completed cause of death (Item 2	3a) (Type.				-				
	0		7202 Quisin Gerry	JAY	13.	ه سر	٤,	MO	20	72=	>	
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 2 0 2005  33 Registrar's Signatur	· /	100							
	, regioti		ITIMI A U LOUS MANUEL JAS.	14								

			1 - State of Maryland / De Registrar				ealth a	and M		giene Reg. No.	05	18808
	Physici	on	Decedent's Name (First, Middle, Last)						2. Date of Dea	ath Day	Year	3. Time of Death
	/Medic		Walter Lee Donaldson, Jr.						May 17	2005	5	9:30 a M
	Examir	ner	4a. Facility Name (If not institution, give street and number)				Location o	f Death			unty of Death	
	F		South River Health & Rehab  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		Edge If Under		If Under 2	24 Hrs.	8 Date of Birt		ie Aru	
l.	Funeral Director		231-36-9572 <sup>1</sup> ⊠ <sup>M 2□ F</sup> 73 Yrs.	- M		Days	Hours	Min.	8. Date of Birt (Month, Day Aug. 5	, Year) 1931	. Was	nplace (State or Foreign untry) hington, DC
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	r Locat	tion							10d. Inside City Limits
	Maryli f sho	ō	Maryland Prince George's Bowie									1 ☐ Yes 2 🕅 No
	r 28a	Director	10e. Street and Number		10f. Zip	Code				10g. Citizen	of What Cou	untry?
	h with	O E	12444 Fletchertown Road		20	720			·	U.S.A	١.	
	ems (	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Armed Forces?	3. Was	s Decede	ent of Hi	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)		Race - Amer Black, White	
36	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Items 23a or 28a-1 show ont, the Medical Evantiner must be notified at	by Fu	1 □ Never Married 2 □ Married 1 □ X Yes 2 □ No   Yes, Give   3 ☑ Widowed 4 □ Divorced Year or Dates: Korea		Yes 2		Specify:	,	· modify of only			ite
8	hour turel	ed b		ceden	t's Usual	Occupa	tion				of Business/I	
7.	in 72 n "na Nedic	Completed	(Specify only highest grade completed) (Gi	ive kind	d of work	k done d e retired	luring most )	of worki	ing	TOD. KING	or business/i	ndustry
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Maryland 21215-0036	m - 0 2	Be	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name	(First, Middle,	Maiden Sur	name)	
<u> </u>	permit. Pages 1 and 2 should be l Department of Heath and Mental I Important: If item 27 is marked or eny injury or other treumatic eve once.	2	Walter Lee Donaldson, Sr.						zabeth			
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	1 and Health em 27 ther to		20a Method of Disposition 20b. Place of Dis	spositio	on (Nam	e of			ie, Mar		20 / 21 on - City or T	Town State
ခွဲ	Pages nent of I int: If it		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	cremato	ory or oth	her place						
Baltimore,	artme ortan injury		'4 □Donation 5 □Other (Specify) Fort Li  21. Signature of Funera†Service Licensee			-			/2005 _ sch's Fi			Maryland
ä	permit. Departr Imports eny inji		Honstone Basch						, Hyati		the second of	PRODUCT SERVICE
			23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	enter ti	he mode	of dying	g, such as	cardiac o	r respiratory ar	rest,	1	Approximate Interval Between
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п	Examiner	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):									
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9	tificate ig phys as the	ledi										
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<u>a</u> .	that the		Part II. Other significant conditions contributing to death but not resulting in the	e unde	rlying ca	usa give	n in Part I		23e Did to	hacco usa c	contribute to	the cause of death?
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S	w require been si should l	Completed							24a. Was a	10 20	lh Wara aut	opsy findings available
Ř	The tav	ш			-				autop perfor	sy med?	prior to co death?	ompletion of cause of
<u>ra</u>		a	25. Was case referred to medical				26 Place	of Death	1 ☐ Yes (Check only or	2 X No	1 🗆 Yes	2 No
	Ø	To B	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	tient	3 DOA	Othe			ne 5 Resid		Other (Speci	(fy)
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<u>0</u>	tending death. tor: Afte the fun	catic	2 Accident investigation		М		′es 2□N	10				
Division	or At tter c Direc in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street,	, factory,	office		2	28f. Location (S City or Tow	treet and Nu n, State)	ımber or Rur	al Route Number,
			29a. Certifier 1 1 Certifying Physician: To the best of my knowledge, de	ath on	ourrad a	t the tim	a data and	t place of	and due to the a	21122/2\ 224		atata d
	e Hospitel 24 hours a e Funerel letely filled	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.	invest	tigation, i	in my op	inion, deat	h occurre	ed at the time, o	ause(s) and late and plac	ce, and due t	to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier		29c.	License	number		2	9d. Date sig	ned (Month,	Day, Year)
						D57	028			May 1	8, 200	)5
2	-11411	Val	30. Name and arrivess of person who completed cause of death (Item 23a) (Typ									
	171	4	Aditya Chopra, M.D. 600 Ridgely Av	renu	ie, S	Suit	e 231	, Ar	mapolis	, Mar	yland	21401
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 2 0 2005									
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PAYSIGNATION  TO SHAPE THE CONTROL OF THE CONTROL O				1 - For Stata Ragistrar	State of Ma	arylan		rtment of I tificate of		and Me	ntal Hy	giene Reg. No		
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Sympa-16-5314   Majer   Maje						NTER				of Death				
The State   The County   The				579-76-5114						Min.	(Month, Da	iy, Year)		
LELIEVIRE D'HAITI   Its Informatr's NamePrelationship (Type, Provi)   Its Informatr's NamePrelationship (NamePrelationship)   Its In		and w		The second secon		10c. City	, Town or Loc	cation						10d. Inside City Limits
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LELIEVIRE D'HAITI   Its Informatr's NamePrelationship (Type, Provi)   Its Informatr's NamePrelationship (NamePrelationship)   Its In	7	d with giene	Com	Elementary/Secondary (0-12)		+)	ACCOUN	TING SE	CRETAR	Υ		EMBA	SSY OF	IVORY COAST
Physician / Medical Examination and contributing in the death. Do not enter the mode of dying, such as carda or respiratory arrest, infrared Ballware, for the medical disease or condition resoluting in death).  **ASPIRATION PNEUMONIA**  **Due to (or as a consequence of):  **Contribute from the medical disease or or or plant in the past of the death). The past of the death in the death in the past of the death in the dea	Igilia	uld be file Jental Hy Irked othe tic event	To Be C	17. Father's Name (First, Middle, Last LELIEVIRE D HAI										
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Physician / Medical Examination and contributing in the death. Do not enter the mode of dying, such as carda or respiratory arrest, infrared Ballware, for the medical disease or condition resoluting in death).  **ASPIRATION PNEUMONIA**  **Due to (or as a consequence of):  **Contribute from the medical disease or or or plant in the past of the death). The past of the death in the death in the past of the death in the dea	າ ນົ	1 and 1ealth sm 27 ther tr		CHRIST FOURCAND/	SON	20h Pl								
Physician / Medical Examination and contributing in the death. Do not enter the mode of dying, such as carda or respiratory arrest, infrared Ballware, for the medical disease or condition resoluting in death).  **ASPIRATION PNEUMONIA**  **Due to (or as a consequence of):  **Contribute from the medical disease or or or plant in the past of the death). The past of the death in the death in the past of the death in the dea		ages nt of h		1 🖾 Burial 2 🗆 Cremation 3					<i>се)</i> И. 5					
Physician / Medical Examination and contributing in the death. Do not enter the mode of dying, such as carda or respiratory arrest, infrared Ballware, for the medical disease or condition resoluting in death).  **ASPIRATION PNEUMONIA**  **Due to (or as a consequence of):  **Contribute from the medical disease or or or plant in the past of the death). The past of the death in the death in the past of the death in the dea	Dalli	permit, P Departme Importani any injury		21. Signature of Funeral Service Lice	nsee	<b>P</b> 1111	22.	Name and Addre	ss of Facilit	y HINE	S-RIN	ALDI	FUNERA	AL HOME INC.
A SPIRATION PNEUMONIA   1 DAY				23a. Part1. Ent the disease, or com shock, or he dilure. List only	plications that caused one cause on each lir				ng, such as	cardiac or r	re <i>s</i> piratory a	rrest,		Interval Between
PROPOSED TO SERVICE A STATE OF THE PROPOSED TO				disease or condition				NIA						1 DAY
FEMALE:   236. Ms a decedent pregnant   1   230. If yes, outcome of pregnancy   1			miner	Cause (Disease or injury				RE/VENTI	LATOR	DEPEN	DENT			1 YEAR
FFEMALE:   23d. Date of delivery   23d. Date of deli	,007	tte be exec lysician ar ne burial-ti	icai Exa	resulting in death) Last	Due to (or as	a consequ	uence of):							
Second	9	- D 6		IF FEMALE:										
Second	0	the death of the attenoched for us	ysician/	in the past 12 months? 1 🗆 Yes 2 🔼 No	1□Live birth 4□Pregnant at	2 Fetal	death 3		у					
Second	, Land	quires that n signed by uld be deta	by P	Part II. Other significant conditions of	contributing to death b	ut not resu	ulting in the un	derlying cause gr	ven in Part I.					
26. Place of Death (Check only one)  27. Manner of Death 1		e ta has e 2	ompiet								auto	psy ormed?	prior to death?	completion of cause of
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  PAUL DEVORE, M.D. 4203 QUEENSBURY RD. HYATTSVILLE, MD 20708	2	cian: ertifica ector,	O							of Death (		-		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  PAUL DEVORE, M.D. 4203 QUEENSBURY RD. HYATTSVILLE, MD 20708	5	Phyai this c	မ	1 ☐ Yes 2 ☐No	1 LX inpatie			J DOA	4 🗆 140	_				ecify)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  PAUL DEVORE, M.D. 4203 QUEENSBURY RD. HYATTSVILLE, MD 20708	=	ding h. After funer	tion	1 Natural 5 Pending	(Month, Day	Year)		Wo	rk?		u. Describe	now injui	y occurred	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  PAUL DEVORE, M.D. 4203 QUEENSBURY RD. HYATTSVILLE, MD 20708	N N N	after deat after deat Director: d in by the	ertifica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Inju	ury - At ho c. (Specify	me, farm, stre							Rural Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  PAUL DEVORE, M.D. 4203 QUEENSBURY RD. HYATTSVILLE, MD 20708		ie Hospits 24 hours ie Funeral letely fillex		(Check only 2 Medical Exal	miner: On the basis of	examinat	wledge, death ion and/or inv	occurred at the ti estigation, in my	me, date an opinion, deat	d place, and th occurred	d due to the at the time,	cause(s) date and	and manner a d place, and du	as stated. se to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  PAUL DEVORE, M.D. 4203 QUEENSBURY RD. HYATTSVILLE, MD 20708  31. Date filed (Month, Day, Year)  32. Senistrar's Signature		To the within To the comp	Me	29b. Signature and title of certifier	1 - 1			29c. Licen:	se number			29d. Da	te signed (Mor	nth, Day, Year)
PAUL DEVORE, M.D. 4203 QUEENSBURY RD. HYATTSVILLE, MD 20708		-		1 Chul	enle	1/1	w>		001852	-		MAY	16, 20	005
31 Date filed (Month Day Year) 32-Registrar's Signature		2							SVTI.I.F	. MD	20708			
Projective MAY 1 9 2005				31. Date filed (Month, Day, Year)	32 Registra		hura e	2.3		.,				

		1 - State Registrar Amend Item  1. Decedent's Name (First, Middle, Last)			inicate or		2. Date of Death	€ 0 0	3. Time of Death
Physic /Medi		HERMAN EDWARD EIG					Month 05/19/20	Day Year	9:00 A M
Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Dea	ith	4c. County of Dea	ath
		CASEY HOUSE				KVILLE			GOMERY
Funeral Director		5. Social Security Number 6. Sec.	7. Age (In yi ≩M 2□F 94	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		Year) 9. Bit	rthplace (State or Foreign country)
		Usual Residence of Decedent  10a, State 10b, County		City, Town or Lo	agation		01/07/19	11	NEW YORK
r 28a-f show	tor	MARYLAND MONTGON		City, Town of Et	BETHESDA				1 Yes 2 XNo
or 288	Director	10e. Street and Number	D #1015		10f. Zip Code	0007/	10	g. Citizen of What C	
s 238		5225 POOKS HILL ROA	AD #4U45  12. Was Decedent Ever in	116		20874	Casafi Van an Na	U.S.,	
n /2 nours aller death with the Maryland "natural", or ttems 23a or 28a-f show offer Evenine froughte nutified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	Black, Whi	ite, etc.
natura	Completed	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Occup kind of work done	during most of w	orking 1	6b. Kind of Business	s/Industry
withir ene. than	ompi	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired RY / SUPPLY	•	ry Oi	WNED GROCI	FRY STORE
be filed htal Hygi od other evant, I	Be	17. Father's Name (First, Middle, Last)		101000	,		ame (First, Middle, M		DIVING
should be and Mental I amarked o	2	JOSEPH  19a. Informant's Name/Relationship (Ty	EIG	19h Maili	na Address (Street	REBECO	CA Rural Route Number,	City or Town State	ROSENBERG
s 1 and 2 should f Health and Men fem 27 is marke other traumatic		JOANNE SICKMEN, DAU			•		E, ROCKVI		
permit. Pages 1 and 2 s Department of Health an Importent: If item 27 is any injury ocother trau		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	1	. Place of Dispo cemetery, crea	osition (Name of matory or other plac	ce)	Date 2	0c. Location - City or	r Town, State
ortent:		'4 □ Donation 5 □ Other (Specify)  21. Signature of husual Service License			ON CEMET		2/2005 A	DELPHI, MA	ARYLAND
Depril Impo		Marin		DA	NZANSKY-	GOLDBÉRO	MEMORIAL E, ROCKVI	CHAPELS,	INC. LAND 20852
Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	ications that caused the de ne cause on each line.	End St	age Renal	_		st,	Approximate Interval Between Onset and Death
/Medical Examiner	j	resulting in death)	Due to (or as a cons						
B <del>:</del>	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):		_			
be executed sician and burial-transit	Examine	that initiated events resulting in death) Last	Due to (or as a cons	equence of):					
cate be ex chysician the burial	icai	L.	d						
death certificate e attending phys id for use as the	/Med	IF FEMALE:	3c. If yes, outcome of pred	nancv				23d. Date of de	divon
at the death by the atten tached for u	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify)	<u> </u>		Month	Day Year
es ing	by	Part II. Other significant conditions con	ntributing to death but not r	esulting in the u	nderlying cause giv	en in Part I.		_	o the cause of death?
v require been si should I	eted								robably 4 Dunknown
the ate h page	e Completed	25. Was case referred to medical					24a. Was an autopsy perform	prior to death?  ∑ No 1 ☐ Yes	utopsy findings available completion of cause of
G 5 €	To Be	examiner?	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	nt 3□ DOA Oth	O.C.	eath (Check only one Home 5 Residen		ecify) HOSPICE
Affer Affer fune	11.	27. Manner of Death 1 ★ Natural 5 □ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time o Injury	Wor	y at k? Yes 2 □ No	28d. Describe how	v injury occurred	
deal deal ctor	ertification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe	home, farm, str cify)			28f. Location (Stre City or Town,	eet and Number or R State)	lural Route Number,
_ 0	dical C	29a. Certifier 1 Certifying Physical Examinates	sician: To the best of my k ner: On the basis of exame and manner stated.	nowledge, deat ination and/or in	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occ	ce, and due to the cau curred at the time, dat	use(s) and manner a e and place, and du	s stated. e to the cause(s)
Hospita 24 hours Funere stely fille			-1/		29c. Licens	e number	296	d. Date signed (Moni	th. Dav. Year)
o the Hospite within 24 hours To the Funere completely fille	Me	29b. Signature and till of certifier	1/					-1.	
within 24 hours after To the Funerel Dire completely filled in E	Me	29b. Signature and this of contrilly	Hi -		- 04	1-1-		5/19/0	05

Amend #	State of Maryland / Dep #19b.Per FH PGC 5-23-05 cr Ce	eartment of Health and M Prtificate of Death	nental Hygiene Reg. No.	DOOF LOOK
Physician /Medical			2. Date of Deeth May 18	2005 3. Time of Death 7:50 AM
Examiner	An English bloom of the net institution, since street and number	4b. City, Town, or Lo Gaither:		County of Death Ontgomery
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Yrs.	y If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9/2/1923	9. Birthplace (State or Foreign Country) China
ath with the Marylend 23a or 28e-f show ust be notified at	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L  Maryland Montgomery Gaithers	sburg		10d. Inside City Limits 1
b with t	10e. Street and Number 174 Lazy Hollow Drive	10f. Zip Code 20878		zen of What Country?
J20 us after des uit, or heme tramfret.m	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U,S. Armed Forces?  1 Styres 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: <b>Chinese</b>
Maryland 21215-0020 d 2 should be filed within 72 hours aff the end Mentel Hygiene. The merked other than "natural", or traumetic event, the Medical Evant traumetic event, the Medical Evant To Be Completed by F	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  12  S+  Matl	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) hematician	ing	nd of Business/Industry  S. Government
and the filed other sevent,	17. Father's Neme (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maiden	
Maryland to 2 should be file the end Mentel Hy ty 1s marked other traumatic event. To Be C	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ling Address (Street and Number or Rur	heen Chan  al Route Number, City of	r Town, State, Zip Code)
Heall ther	Alan Eng (Son) 6404  20a. Method of Disposition 20b. Place of Disposition cemetery, cre	osition (Name of	Date 20c. Lo	Canding, Md 20779 cation - City or Town, State cland, Maryland
Baltimor pemit. Pages Department of Important: if it any Injury or c	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Cedar Hill Fune	ral Home,i	
Physician /Medical Examiner	resulting in death)  a  Due to (or as e conse	cer	or respiratory arrest,	Approximate Interval Between Onset and Death
Box 68760, aath certificate be axecuted attending physician and for use es the burial-transit claryMedical Examiner				
P.O. Box (hat the death certified by the attending detached for use ere Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23b. Did tobacco	use contribute to the cause of death?
/ital Records, P.O. Box E claim: The law requires that the death certificate has been signed by the attending setor, page 2 should be detached for use estor, page 18 by Physiclan/Me			24a. Was an autop performed?	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
Vision of Vita Attanding Physicien: or death. ector: After this certifice by the funeral director, iffication: To Be (	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	ont 3 DOA Other: 4 Nursing Ho of 28c. Injury at Work? M 1 Yes 2 No	h (Check only one) ome 5 residence 6 28d. Describe how injur 28f. Location (Street and City or Town, State,	y occurred  d Number or Rural Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea cone)  2 Medical Examiner: On the basis of examination and/or in and manner stated.			
To the within 2 To the comple		29c. License number D 4308	> A / A	e signed (Month, Day, Year)
State Registrar	30. Name and address of person who completed cause of death (fem 23a) (Type SECINGS A SOTOS MO 9707 MGO)  31. Date filed (Month, Day, Year)  MAY 2 3 2005	CAL CENTER DR ;	#300 Poc	1 19, 200] EXULLE, MO 2085

.S			State of Maryland / Department of Health and No. 1 - State of Maryland / Department of Health And No. 1 - State of Maryland / Department of Health And No. 1 - State of Maryland / Department of Health And No. 1 - State of Maryland / Department of Health And No. 1 - State of Maryland / Department of Health And No. 1 - State of Maryland / Department of Health And No. 1 - State of Maryland / Department of Health And No. 1 - State of Maryland / Department of Health And No. 1 - State of Maryland / Department of Health And No. 1 - State of Maryland / Department of Health And No. 1 - State of Maryland / Department of Health And No. 1 - State of Maryland / Department of Health And No. 1 - State of Maryland / Department of Health And No. 1 - State of Maryland / Department / Dep	_	giene) () 5 Reg. No.	18812
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of De Month MAY	10, Day 2005	3. Time of Death  1130 A M
	/Medic Examin		Angelina T. Freise  4a. Facility Name (If not institution, give street and number)  7500 WOODMONT AVENUE # 410  BETHESDA	I II I	4c. County of Death	1
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 1 Months Days Hours Min.			nplace (State or Foreign untry)
	yiand sow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	in 72 hours after death with the Maryland "natural", or Itams 23e or 28e-f show Josef EXA iffer out be notified at	ector	Maryland Montgomery Bethesda		10s Chinas Matheway	X Yes 2 No
	3e or 3	Funeral Directo	10e. Street and Number 10f. Zip Code 20814		10g. Citizen of What Co U.S.A.	untr <b>y</b> ?
	r death	nerg	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No Rican, etc.)		
USP	72 hours after natural', or Ita	by	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 1 □ Yes 2 □ No Specify: Year or Dates:		Specify: W	nite
2-003p	72 hou		15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work	ing	16b. Kind of Business/	
121		Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)  12th Homemaker		Own Home	
	be filed withi tal Hygiene. d other then avent. It e M	O	17. Father's Name (First, Middle, Last)  18. Mother's Name		, Maiden Sumame)	
<u> </u>	2 should be and Mental Is marked raumatic av	2	Amador Gomez  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run.		er City or Town State 7	in Code)
Mar	alth an 127 is				Kansas 661	
altimore,	permit. Pages 1 and 2 should be Department of Health and Menia Important: If item 27 is marked any injury or other traumatic av once.		20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 □ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Fown, State
	artmen ortant: injury B.	. 1	'4 □ Donation 5 □ Other (Specify) MT Comfort Crematory May 1  21. Signature, of Funeral Service Licensee 22. Name and Address of Facility 1.		Alexandria awler's Sons	
ñ	Dep Imp		Williamy R, Burger 5130 Wisconsin Ave	N.W.	Washington	
	Physician		23a. Part1. Enter the disease, or complications that cauded the death. Do not enter the mode if dying, such as cardiac shock, or heart failure. List only one cause in each line.  Immediate Cause (Final disease or condition	or respiratory a	Pisese	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	be executed ician and burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
9/90	cate be executed obysician and the burial-transit	dical E	d			
٥	certificate iding phys	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		22d Date of deli	
O. Box	es that the death certific igned by the attending p be detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1		23d. Date of deli Month	Day Year
rds, r	.= v =	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		robacco use contribute to Yes 2 □ No 3 □ Pro	the cause of death?
Records	ilcian: The law requ certificate has been rector, page 2 shoult	Completed		24a. Was auto perio Yes		topsy findings available completion of cause of
VITal	Physician: r this certifice ral director,	Be	25. Was case referred to medical examiner?  Hospital: Glassia all Documents all Docume			ATE COENE
_	hys I di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		dence 6X10ther (Spec how injury occurred	ify) AT SCENE
sion	lending Feath. or: After the funera	ertification;	2 Accident investigation M 1 Yes 2 No			
Š	or Att after d Diract d in by	ertifi	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	28f. Location (. City or To	Street and Number or Ru wn, State)	ral Route Number,
	To the Hospitel or Attending Pl within 24 hours alter death. To the Funarel Director: After the completely filled in by the funera	ledical C	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.			
,	To th withir comp	Me	29b. Signature and title of certifier  29c. License number  OCME		29d. Date signed (Month) MAY 11, 20	
			30, Name and address of person who completed cause of death (Item 23a) (Type, Print)  111 Penn Street	Baltimo	re, Maryland	d 21201
į	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 9 2005  33. Registrar's Signature			

Samuel Feldman 05-03359 RPD

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	aryland / Dep ————————————————————————————————————	ertificate of			giene leg. No. 0	05	18813
	Physici /Medic		Decedent's Name (First, Middle,     SAMUEL	, Last)		FELDMA	N	2. Date of Dea Month May 14	Day	Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, Old Georgetown		Lane	4b. City, Town, o	or Location of Dea		4c. County Montg		
l	Funeral Director		050-10-6096	6. Sex 7. Age 1 ☑ M 2 ☐ F	88 Yrs.	) If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year)		lace (State or Foreign try)
	show		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L						0d. Inside City Limits
	h the Ma or 28a-f s	Director	MARYLAND MONTGO	OMERY	ROCKVILL	E 10f. Zip Code		1	log. Citizen of V	What Count	1X Yes 2 No
	eath wit	Funeral D	11430 STRAND DR		ever in IIS 12	Was Decedent of t	20852	Sanata Van an Na		U.S.A	
036	thin 72 hours after death with the Marylar e an "natural", or Items 23a or 28a-f show Macical Exterinations to notified at	b	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 ☒ N If Yes, Give Year or Dates:	0	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Specify:	to Rican, etc.)	Blad	e - America ck, White, e	etc.
9500-6121	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ha Modical Examinar must be notified at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or 5-	+) (Giv.	edent's Usual Occup e kind of work done DO NOT use retire	during most of wo d)	orking	16b. Kind of Bu		ustry
and 2	be filed value Hygie d other i	Be Co	17. Father's Name (First, Middle, L	5+ ast)	ELEC	TRICAL EN		me (First, Middle, i	U.S. NA Maiden Suman		
<u> </u>		To	JOSEPH FELDMAN  19a. Informant's Name/Relationshi	ip (Type, Print)	19b. Mail	ing Address (Street		SCHWARTZ		State Zin	Code
e, Mar	other trau		MARTIN S. FELDMA	AN/SON	1820	O IDYLWIL		LOS GATO	S, CAL	[FORN]	IA 95033
baitimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 1 □ Donation 5 □ Other (Spi	3 ⊋Removal from State ecify)		osition (Name of smatory or other place LD MEML G	1057		20c. Location - 'ALLS CH		wn, State VIRGINIA
gal	permit. Depart Import any inj		21. Signature of Funeral Service Li	Stattle	nees_ 2	2. Name and Addre DANZANSKY LI/U ROCK	ss of Facility GOLDBER	G MEMORIA	L CHAPE	ELS, I	INC. AND 20852
H			23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final			ter the mode of dyir	ig, such as cardia	c or respiratory arre	est,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	aDue to (or as a	cons uence of):	njuvil	5				
B		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of):						
00/00	tificate be executed yg physician and as the burial-transit	al Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence of):						
		Medical	IF FEMALE:	d							
.O. DOX	The law requires that the death certate has been signed by the attendingege 2 should be detached for use.	Physiclan/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	⊒Ectopic pregnancy □ Other (specify)			23d. Date Mor	e of delivery nth D	y Day Year
cords, r	w requires that been signed t should be det	þ	Part II. Other significant condition	s contributing to death but	t not resulting in the u	inderlying cause giv	en in Part I.	23e. Did tob	4/		e cause of death?
	: The law r cate has be page 2 sh	Completed						24a. Was ar autops perform 1 🗷 Ves 2	ped? d		sy findings available pletion of cause of
N II d	ysician is certifi director	To Be	25. Was case referred to medical examiner?  1 XYes 2 No	Hospital: 1 ☐ Inpatien	t 2 ER/Outpatie	nt 3□ DOA Othe		ath (Check only one		er (Specify)	At Scene
5	nding Ph th. : After th s funeral		27. Manner of Death  1 □ Natural 5 □ Pending 2 🔀 Accident investiga	28a. Date of Injury (Month, Day	28b. Time o	f 28c. Injun Work		28d. Describe ho	w injury occurre	ed ,	vehille
DIVIS	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could no 4 Homicide determin	t be 200 Stage of Injur	y - At home, farm, str (Specify)			28f. Location (Str City or Town	eet and Number, State) 01d	600	Route Number, uge town Rd KUILLE MD
	e Hospil 24 hour e Funeri etely fills	Medical	29a. Certifier 1 Certifying (Check only one) 2 X Medical Ex	Physician: To the best of caminer: On the basis of and manner state	my knowledge, deat examination and/or in	h occurred at the tin	ne, date and place pinion, death occu	and due to the on	uso(a) and mas	nor no stat	and
	To the To the Complex	Me	29b. Signature and title of certifier	^	Α.	29c. License			d. Date signed		ay, Year)
	5		30. Name and address of person when the control of	allan h	ath (Item 23a) (Type,	Part 1 Dans	Stroot		ay 15,		21 201
100	* Sta		CAROL H f 31. Date filed (Month, Day, Year)	100///			Street	Baltimor	e, Mary	, Land	21201
	Registra		REAV 90	2005	. B. GO	wer					

JOHN L. FALLON 05-03668 amend/unpend 1tem/1,23a,27,28a-f, perME, 6344,678705 TII Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene RKD For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last)

John L. Fallon, Jr. 2. Date of Death 3. Time of Death Month MAY **Physician** 2005 12:11A. J<del>ohn Louis Fallon Sr</del> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON COUNTY HOSPITAL WASHINGTON HAGERSTOWN If Under 1 Year | if Under 24 Hrs. Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months 1X M 2□ F 37 29,1968 District Columbi Director 577-90-5174 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b County or 28e-f show Examiner must be notified at 1 X Yes 2 □ No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 52 South Cannon 21740 U.S.A. 230 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Marital Status 72 hours after 1 X Never Married 2 Married Saltimore, Maryland 21215-0036 0 1 ☐ Yes 21 No Specify: Specify: White 3 Widowed 4 Divorced "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 11 Carpenter Construction other treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John Louis Fallon Be marked of Betty Lou Langhorne မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kendrick/foster Mother 52 South Cannon Hagerstown MD 21740 f Health Nancy 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Importent: If ite any injury or of once. 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/31/2005 Smithsburg, Maryland ¹ 4 □ Donation Smithsburg Crematory 21. Signature of Funeral Service Picenses 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cocaine Intoxication /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical the IF FEMALE: Se 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown sign**e**d b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, Š 1 Yes 2 No 3 Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 1968 2 2 No 24a. Was an page 2 s autopsy performed cate 2□ No Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes ۵ 2 No 2 XER/Outpatient 3 DOA 27. Manner of Death Find Jonth, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1111k Fndjury of Certification: After 1 Natural 5 Pending investigation 1 🗌 Yes 11:50 PM 5/27/05 2 Accident Director: / 6X Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 52 S. Cannon Ave. determined 4 - Homicide Found at home Hagerstown, MD within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME MAY 28, 2005 been MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201

DHMH 17 Rev 1/200

State Registrar 31. Date filed (Month) ON Or) 6 2005

egistrar's Signatur

		_ For	State of Maryla	and / Dep	artment of H	Health and i	-	-		188	15
		State Registrar		Се	rtificate of	Death		Reg. No.			
Physic	ian	Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of	
/Med		Grace Louise Fink	(AKA-Louis	se K. Fi			May 30		-4 D45	1:45	A <sup>M</sup>
Exam	iner	4a. Facility Name (If not institution, give st				or Location of Deat	n	4c. County			
Europe		Homewood at Crumlar  5. Social Security Number 6. Sex		rs. last birthday	Frederic  If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	Frede:		lace (State o	r Foreign
Funera Director			M 2 💆 F 8	3 Yrs.	Months Days	Hours Min.	(Month, Da Mar. 2	, 1922	Mary	try) Land	
P .		Usual Residence of Decedent	40	O'r. T						0d. Inside Ci	h . I !!
arylar shov	<u>_</u>	10a. State 10b. County		City, Town or L	ocation					od. mside Ci 1 ☐ Yes	*
the M	ecto	Maryland Frederick  10e. Street and Number	Fre	derick	10f. Zip Code			10g. Citizen of	What Cour	trv?	
with a or	Funeral Director	7407 Willow Road			21702			USA	renar cour	ay:	
death ms 23	era		2. Was Decedent Ever in	U.S. 13.	Was Decedent of I	Hispanic Origin? (S			e - Americ		
or Ite	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2 ☒ No		to Hican, etc.)		ck, White,	etc.	
Z I Z I 3-0030 d within 72 hours af giene. or than "naturel", or ine Medical Expri	d by	3 ⅓ Widowed 4 ☐ Divorced	Year or Dates:		7-			Specif	Whit		
72 h 72 h	Completed	15. Decedent's Educa (Specify only highest grade	ation completed)	16a. Dece	edent's Usual Occup e kind of work done DO NOT use retire	pation during most of wo	rking	16b. Kind of B	usiness/In	lustry	
withir sne.	mp	Elementary/Secondary (0-12)	College (1-4or 5+) 4	teach		iu)		public	oduc	ation	
filled Hygical Sther	ပိ	17. Father's Name (First, Middle, Last)		Leaci	ICI	18. Mother's Nar	me (First, Middle			ation	
VIZING build be file Mental Hy arked oth attic event	To Be	Gilmore Hine Keller	•			Grace An	rnold				
Marylan 2 should be and Mental 7 is marked c	-	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mail	ing Address (Street	t and Number or Ru	ural Route Numb	er, City or Town,	State, Zip	Code) 21	701
5 ± 2 ±		Joseph Welty, attor		30 We	est Patri	ck Street					
of Hear		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	20b	<ul> <li>Place of Disp cemetery, cre</li> </ul>	osition (Name of matory or other pla	ice)	Date	20c. Location	City or To	wn, State	
Dallimor Dermit. Pages Department of Importent: If it any injury or o		'4 □Donation 5 □ Other (Specify)			et Cemete			Frederi			
Dall permit. Depart Import any inj		21. Signature of Funeral Service Licenses			2. Name and Addre						
n gorgo					l06 East				c, MD		
		23a. Part1. Enter the disease, or complic shock or heart failure. List only one				ing, such as cardial	c or respiratory a	rrest,		Approximate Interval Bette Onset and I	ween Death
Frysician /Medica	_	Immediate Cause (Final disease or condition resulting in death) a.	Cerebrovas		ccident					mont	h
Examine			Due to (or as a cons Hypertensi						50	) year	c
The same	e e	Sequentially list conditions, if any, leading to immediate cause. Exter underlying Cause (Disease or injury that initiated events c.	Due to (or as a cons						- [	year	-
cuted	Examiner	Cause (Disease or injury that initiated events									
fou, e be exe sician ar e burial-t		resulting in death) Last	Due to (or as a cons	equence of);							
	dical	d.									
X 00 sertificat ding physe as th	/Med	IF FEMALE: 23	c. If yes, outcome of pre	enancy				03d Do	te of delive		
death cer death cer ne attendir ed for use	Physician/M	in the past 12 months?	1 Live birth 2 □Fi 4 □ Pregnant at time of	etal death 3	□Ectopic pregnanc □ Other (specify)	;y			nth	*	Year
the d	nysi	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	9□ Unknown								
ords, F.C requires that the een signed by th hould be detache	by Pi	Part II. Other significant conditions cont	ributing to death but not i	resulting in the	underlying cause gr	ven in Part I.	23e. Did t	obacco use con	ribute to th	e cause of d	eath?
guire an sig nuld b	ed b	Coronary Artery Di	sease, Deme	ntia			1 🗆	Yes 2∑No	3 Prob	ably 4 □L	Inknown
HECOLOS he law requires has been sign ige 2 should be	ompleted						24a. Was	an 24b.	Were auto	psy findings a	available ause of
The The ate his page	Com						perfo 1 ☐ Yes	ormed?	death?	2 No	
OT VITAL MEC Physician: The law this certificate has b	Be (	25. Was case referred to medical examiner?					ath (Check only				
OT N Physi	2	TL Tes ZLANO	ospital: 1 Inpatient 2	71 0:		her: 4 X Nursing F				<i>'</i> )	
SION OT VITA tending Physician: teath. tor: After this certific the funeral director,	lon	27. Manner of Death 1 XNatural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time ( Injury	Wo	nryan ork? ]Yes 2∐No	28d. Describe	how injury occur	rea		
UNISION I or Attending after death. Director: Afte	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - A	t home, farm, s			28f. Location (	Street and Numb	er or Rura	I Route Num	ber,
affor A Dire	Certification:	4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	ecify)			City or To	wn, State)			
sspite hours inerel y filled		29a. Certifier 1 X Certifying Physi	ician: To the best of my	knowledge, dea	th occurred at the ti	ime, date and place	e, and due to the	cause(s) and ma	anner as s	ated.	,
DIVISION To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical	one)	er: On the basis of exam and manner stated.	ination and/or it			urred at the time,				}
To t	Σ	29b. Signature and title of certifier	$\supset$		29c. Licen	se number		29d. Date signe	d (Month,	Day, Year)	
/		" leust -	Joanne	Appropriate to	D09689	9	1	May 31,	2005		
5		30. Name and address of person who cor Austin Pearre, MD,				derick M	Jarvland	21701			
	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sig		cer, rie	uciick, M	ar y raiid	21/01			
Regis			005	-	1. 4.						

DHMH 17 Rev 1/2001

ORIGINAL

		1 - State of Maryland / Dep	partment of Health and Nertificate of Death		ege005   88 6
Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year
/Medic	al	CLIFFORD B. GLOVER  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Locetion of Death	MAY	17, 2005 4:34A M
Examin	er	NORTH ARUNDEL HOSPITAL	GLEN BURNIE		ANNE ARUNDEL
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		8. Date of Birth (Month, Day, )	9 Birtholace (State or Foreign
Director		218 98 3168 XXM 2□F 37 Yrs.		NOV. 07,	
land		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	ocation		10d. Inside City Limits
Mary a-f sh	tor	MARYLAND MONTGOMERY GAITHERS	BURG		XM∑Yes 2 □ No
ith the	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?
s 23a		10516 BOUNTY COVE COURT	20770	- it Van an Na	UNITED STATES  14. Race - American Indian,
within 72 hours after death with the Maryland jiene. r then "naturel", or Items 23a or 28a-f show the Medical Exam mentiost ter txdiffed at	Funeral	Armed Forces?	<ul> <li>Was Decedent of Hispanic Origin? (Sp. 1f Yes, specify Cuban, Mexican, Puerlo</li> </ul>	Rican, etc.)	Black, White, etc.
el', or	by	1 □ Never Married 2 Married 1 □ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2√√No Specify:		Specify: BLACK
72 hc	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation re kind of work done during most of wor	king	6b. Kind of Business/Industry
within 72 ene. then "nat	mp	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)  ANCIAL COUNSELOR		PRIVATE
F the first	e Co	17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma	
should be and Mental I marked o	To B	CLIFFORD B. GLOVER, SR.	JAMESETT	A HANBERF	RY
2 should and Men le marke eumatic		19a. Informant's Name/Relationship (Type, Print)	iling Address (Street and Number or Ru	ral Route Number,	City or Town, State, Zip Code)
as 1 and 2 should be of Health and Ment litem 27 le markec rother treumalic e			FAIRHILL DRIVE		ND MD 20746  Oc. Location - City or Town, State
Pages nent of H int: If ite iry or of		Masurial 2 Cremation 3 Hemoval from State	position (Name of ematory or other place)		•
C 49 -3			ON NATIONAL CEM. 1	Contract to the Party Street S	SUITLAND, MD
permit. Depart Import eny inj		$\mathbf{F}(\mathbf{V}, \mathbf{V}, \mathbf{W}, \mathbf{W}, \mathbf{W}) = \mathbf{F}(\mathbf{V}, \mathbf{W}, \mathbf{W}, \mathbf{W})$	22. Name and Address of Facility MARSHALL'S FUNERAL 4308 SUITLAND ROAI		MARYLAND, INC. AND, MD 20746
Physician //Medical Examiner	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. CHRONIC CONGESTI Due to (or as a consequence of):  VENTRICULAR IRRADULE (or as a consequence of):  VENTRICULAR FIBREDULE (or as a consequence of):	TABILITY		Onset and Death
death certific e attending p nd for use as	Physiclan/Medi		□ Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
law requires that the de as been signed by the a 2 should be detached f	b	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to the cause of death?
i: The law requicate has been	Completed			24a. Was an autopsy perform	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
siclen: certifica irector, p	BeC	25. Was case referred to medical examiner?		ith (Check only one,	
ding Physic h. After this ce funeral dire	၉	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ✓ ■ FVOutpat  27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, Day Year)  28b. Time (Month, Day Year)	of 28c. Injury at	ome 5 Residen	ice 6 Other (Specify) v injury occurred
Atten ir deat ector: by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
To the Hospital or within 24 hours after To the Funerel Dircompletely filled in	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de (Check only one)  Certifying Physician: To the best of my knowledge, de (Check only one)			
To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, Day, Year)
		· complete	D14404	1	1ay 12, 2005
-(3)		30. Name and address of person who completed cause of death (Item 23a) (Typ		1.00 CTT	ED CDDING MD 20004
		CHARLES L. FRANKLIN, JR. 11120 NI  31. Date filed (Month, Day, Year)  327 Registrar's Signature	W HAMPSHIKE AVE.	14U8 SILV	ER SPRING, MD 20904
Sta Registi		MAY 2 3 2005			

				State of Maryland / Department of Health and I  State Registrer  State Certificate of Death		one No.005 18817
		Physici	an	1. Decedent's Name (First, Middle, Last) ETHEL L. GILLIAM	2. Date of Death Month	Day Year 3. Time of Death
		/Ḿedio Examir	cal	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	5 /	4c. County of Death
	1	Exami	lei	Lorien @ Riverside Balcam		Harford
		Funeral		5. Social Security Number 216-42-5066  6. Sex 1 M 2 F  7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	(Month, Day, Y	9. Birthplace (State or Foreign Country)
		Director		Usual Residence of Decedent	Jan 6, 19	936 North Carolina
		72 hours after death with the Maryland naturel', or Items 23s or 28s-1 show dical Exaculational by notified at	_	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 ☐ Yes 2 🕅 No
		s after death with the Marylar , or Items 23a or 28a-1 show on the final be incilled	Director	Maryland Harford Belcamp  10e. Street and Number 10f. Zip Code	100	. Citizen of What Country?
		h with		1123 Belcamp Garth 21017		USA
7		after deat or Items 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
Silliam	36	rs afte	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Yes 2 ☒ No Specify: Year or Dates:		Specify: Black
1	5-0036	72 hou nature lical E		15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work	ting 16	b. Kind of Business/Industry
25	21	E = #	Completed	Elementary/Secondary (0·12) College (1·4or 5+) life. DO NOT use retired)	king	Public Schools
0	d 21		a)		ne (First, Middle, Mai	
1	/land	0 to 0	To B	Levy Ford Mary Le	e Price	
_	Man			19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru		
0	e,	and n 2 n 2		Barbara Kell / sister 634 Walker Street, Ak  20a. Method of Disposition 20b. Place of Disposition (Name of	The state of the s	D 21001 c. Location - City or Town, State
7	mo	00-		1 XBurial 2 □ Cremation 3 □ Removal from State  1 Y Donation 5 □ Other (Specify)  1 X Burial 2 □ Cremation 3 □ Removal from State  1 X Burial 2 □ Cremation 3 □ Removal from State  1 X Burial 2 □ Cremation 3 □ Removal from State  1 X Burial 2 □ Cremation 3 □ Removal from State  1 X Burial 2 □ Cremation 3 □ Removal from State  1 X Burial 2 □ Cremation 3 □ Removal from State  1 X Donation 5 □ Other (Specify)	avre de Grace, MD	
Ш	Baltimore,	permit. Pag Department Importent: I any injury c		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Lisa Scott Fune  552 Lewis Street	eral Home,	P.A.
				23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.		
		Priysician	, IV	Immediate Cause (Final disease or condition		Onset and Death
		/Medical Examiner		Due to (or all a consequence of):		2/24
			Jer	Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury		7700
4	2	acuted nd transit	Examiner	that initiated events c.		
	8760,	sician and burial-transit		resulting in death) Last Due to (or as a consequence of):		
	687	ficate p physics to the	edica	d		
	Вох	eath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant in the cast 10 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery
	P.O. B	tt the dea by the att	Physician/Medical	in the past 12 months?  1		Month Day Year
	٥.	s that the ned by a detac	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
	rds	w requires been sign should be	ed b	an Pry's	1 🗆 Yes	2 No 3 Probably 4 Unknown
	ecc	e faw re has be je 2 sho	ompleted		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
	Division of Vital Records,	icien: The l certificate ha rector, page	O		performer 1 □ Yes 2	d2   death? No 1 □ Yes 2 □ No
	VIII	ysicier is certif directo	To Be	examiner?	th (Check only one)	e 6 Other (Specify)
	n of	ding Phys h. After this funeral di		27. Manner of Death 1 Construct 5 Pending 28a. Date of Injury 28b. Time of Injury Work?	28d. Describe how	
	Sio	Attendii death. ctor: A y the fu	cati	2 Accident investigation M 1 Yes 2 No	006 1	
	Div	al or Atten after deat I Director: d in by the	Certification:	3 ☐ Stricide 4 ☐ Homicide  5 ☐ Could not be determined building, etc. (Specify)	City or Town, S	at and Number or Rural Route Number, State)
		To the Hospital or Attanding Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of the control of the basis of examination and/or investigation, in my opinion, death occur and manner stated.	, and due to the caus rred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
		To the To the Comple	Me	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month, Day, Year)
				De Melle 127975	5/	19/05
		\		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) and Mel	An Mr.	121014
		Sta Registr		31. Date filed (Month, Day, Year)  MAY 2 3 2005  MAY 2 3 2005		

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month MAY Physician 2005 GIOVANNI GIULIANI 22:28 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CECIL UNION HOSPITAL ELKTON If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5 Social Security Number **Funeral** Months 1 🕅 M 2 🗆 F 75 222 26 8784 ITALY Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County or 28e-f show treumatic event, the Medical Examiner rest be notified at 1 ☐ Yes 21 No Director MD CECIL NORTHEAST 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 551 TRINITY CHURCH ROAD 21901 IISA or Items 23a Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CARPENTER CARPENTRY 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental ! NICOLA GIULIANI MARIA GIULIANI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 551 TRINITY CHURCH ROAD, NORTHEAST, MD 21901 KATHLEEN GIULIANI If Item 27 other 20b. Place of Disposition (Name of cemetery, crematory or other place) MAY 25. 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ö ortent: I 2205 `4 □Donation 5 ☑ Other (Specify) ENTOMBMENT CATHEDRAL CEMETERY WILMINGTON, DE permit.
Departn
Importe
any nju 2. Name and Address of Facility
MEALEY FUNERAL HOMES PO BOX 2866, WILMINGTON DE 19805 CHARLES F. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lung Physician disease or condition resulting in death) /Medical **Examiner** neumomia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 0 D0023322 5.21.2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

\$\int \text{SAGNEV MD} \ \( \text{UFNorts} \) St Swife 118 North St Swite 3B, Elleton MD 21921. S SAGNOEV MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 24 2005 Registrar

			1 - For State Registrar	State of M	aryland / Dep Ce	artment ertificate				Re	eg. No.2 ()	05	181	819
*	Physici	an	1. Decedent's Name (First, Middle, Last)  Irving Lamont 6	laston					2	n Date of Deat Month May	_	ď85	3. Time of 1600	
	/Medic Examin		4a. Facility Name (If not institution, give s		· · · · · · · · · · · · · · · · · · ·	4b. City, To	own, or L	_ocation of	Death		4c. County			
			Casey House			i if I ladar 1		ockvi		(8:4)			omery	-
	Funeral Director		377 70 3313	M 2□F 7. Ag	ge (In yrs. last birthda 54 Yrs.	Months	Days	Hours	Min.	Date of Birth (Month, Day, )ct. 25	, 1950	9. Birthp Court Was	lace (State of htry) Sh., D	)C
	/land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location						1	0d. Inside C	-
	e Man Be-fah	ctor	Maryland Prince G	George's		La	ndov	ver						2 🗆 No
	with th	Dire	10e. Street and Number			10f. Zip C	Code		_	1	0g. Citizen of V			
	death ms 23	Funeral Directo	6903 Hawthorne 11. Marital Status	2. Was Decedent	Ever in U.S. 13	. Was Deceder	nt of His	2078 panic Orig		fy Yes or No-	14. Rac	e - Americ	States an Indian,	3
98	72 hours after death with the Maryland Instural, or Itams 23a or 28e-f ahow Jisal Evaniner must be rollife d'al	y Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces?  1 Yes 2 1  If Yes, Give	No	1 ☐ Yes 2		Specify:	, Puerto Hi	can, etc.)	Specify	k, White,	etc. lack	
9	hours	ed by	3 ☐ Widowed 4 ☑ Divorced  15. Decedent's Educ	Year or Dates: ation		edent's Usual	Occupat				16b. Kind of Bu			
215	within 72 ene. than "ne	Completed	(Specify only highest grade completed)  (Give kind of work done during most of work life. DO NOT use retired)							7	D.	-i ***	•	
121	e filed wi al Hygien othar th vent, I's		Janitor  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)							First, Middle, M	Private  Maiden Sumame)			
an	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If itam 27 Ia marked othar than "neturat", or Itams 23a or 28e-1 ahow or other traumatic event, If a Medical Examiner must be notified at	To Be	Billy James Gaston						· o mamo (			e Taylor		
lary	2 should be and Mental I a marked ( raumatic ev	_	19a. Informant's Name/Relationship (Typ					City or Town,		Code)				
	1 and Health tam 27		De Borah G. Kidd  20a. Method of Disposition	- Sister	20b. Place of Dis	position (Name	e of		.W. V	-	DC 2001 20c. Location -		wn, State	
nor	ages ant of ht: If it y or o		1 ABurial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	emoval from State	cemetery, c	cemetery, crematory or other place)						Wash., DC		
Baltimore,	permil. Pages 1 an Department of Heal Importent: If itam 2 any injury or other once.		21. Signature of Funeral Service License	•A	(I)	22. Name and					uneral		,,,	
_	99E # 9		John 1.	rousk	VIII-						ash., D	C 20		te
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Immediate Cause (Final											
			minediate date (Final disease or condition resulting in death)  Recurrent Colon Cancer with Brain Metastases  Due to (or as a consequence of):											
В	Examiner	_	Sequentially list conditions, b	Due to (or as	s a consequence of):							_		_
	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		a consequence or).									
ő,	ate be executed thysician and the burial-transit		resulting in death) Last		s a consequence of):									
8760,	icate b physic s the b	dica	d									-		
Box 6	death certificate be executed e attending physician and id for use as the burial-transit	n/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy							23d. Date of delivery  Month Day Year				
O. B	ne deat the attr hed for	Physician/Medical	In the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown											
۵.	law requires that the de as been signed by the a 2 should be detached I									23e. Did tobacco use contribute to the cause of d				death?
rds	w requires been sign should be	ted by								1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Inknow				
Vital Records,	e law re has be je 2 sho	ompleted	25. Was case referred to medical 26. Place of Death (Che							autops	24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?			
al F	Th ate pag	e Cor								1 Yes 2 ANo 1 Yes 2 No				
Ϋ́	y S	To B	eyaminer?	ospital:	ient 2 ☐ ER/Outpat	ent 3 DOA	Otho			e 5 ☐ Reside		er (Specif	Hospi	Lce
n of			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury ay Year) 28b. Time Injur	/	c. Injury Work	?		ld. Describe ho	ow injury occur	ed		
Division	tand eath tor: the	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office						(es 2 ☐ No  28f. Location (Street and Number or Rural Route Number,					nber,
Ö	ital or Att rs after d al Diract led in by t	Cert	4 ☐ Homicide determined building, etc. (Specify)  City or Town, State)											
	To tha Hospital or At within 24 hours after d To tha Funaral Diract completely filled in by	29a. Certifier (Check only one)  122 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.										s)		
	To tha within 2 To tha complei	Me	29b. Signature and title of certifier			29c.	License	number		2	9d. Date signe	d (Month,	Day, Year)	
•	(6)		E CARL			- 1	) [	112	18		5/23	5/0	5	
	(2)		30. Name and address of person who co				octo-	r Mil	1 RA	Roofe	ville,	MD	20855	
	Sta	ate	Charles Ha	39. Regist	trar's Signature		aste.	r mil	ı Ku	, KUCK	V 111C	<u>, 111</u>	_0000	
	Regist	rar	MAY 2 3 2005	Blown	K do	1								

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No: 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Day 2005 **Physician** 17, Clara Prince Greene 9:00 P. M Mav /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town or Location of Death Examiner Prince Georges Crescent Cities Center Riverdale If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1908 9. Birthplace (State or Foreign September 9, South Carolina 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min 1 □ M 2 X F 96 Yrs 578-48-3750 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28e-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No District of Columbia Washington Directo permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene.
Important: if item 27 is marked other then "natural any injury or other traumating." 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 222 "V" Street, N. E. 20002 United States Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) I ☐ Yes 2X No 1 Never Married 2 Married 1 ☐ Yes 2 No **Black** Specify: Specify: 3 X Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Technician llth grade Domestic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Wilson Prince Mary Monroe ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Clara Denyce Shields (Daughter) 222 "V" Street, N.E.; Washington, D. C. 20002 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition

1 

Burial 2 □ Cremation 3 □ Removal from State May 21,2005 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland gnature Funeral Sept License 22. Name and Address of Facility R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BA **Physician** 0 disease or condition resulting in death) /Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Box 68760. physician Physician/Medical IF FEMALE use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 X No Day 4☐ Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Tyes 2X No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospitei or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 스 this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending after death. investigation 1 🗌 Yes 2 No 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 19, 2005 20737 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Alexander E. J. Ukoh, M.D.; 4404 Queensbury Road;Suite 110;Riverdale, Maryland 31. Date filed (Month, Day, Year) State MAY 2 0 2005 Registrar

		- State Registraamend item	State of Maryland #17 per fh				F	Reg. No.	05   882		
Physici		1. Decedent's Neme (First, Middle, Last) Lillian E.					2. Date of Dea Month Mary 14	Day Y	3. Time of Death 17:45 P. M		
/Medic Examin Funeral	er	4a. Fecility Name (If not institution, give st Fort Washington Hospita 5. Social Security Number 6. 5.50	7. Age (In yrs. I.		•	r Location of Death  Washington  If Under 24 Hrs.  Hours Min.	8. Date of Birt	4c. County of Prince G	eorge's Birthplace (State or Foreign		
Director		216–19–5565 1□  Usual Residence of Decedent  10a. State 10b. County		Yrs.	nation		September	r 23,1913 M	aryland  10d. Inside City Limits		
death with the Maryland rms 23a or 28a-f show rmust be notified at	Director	Maryland Prince Geor	ge's		SU 10f. Zip Code	itland ————		10g. Citizen of Wh.	1 X es 2 □ No		
s 23a or 3		2208 Porter Avenue	2. Was Decedent Ever in U.	S 12 V		20746 dispanic Origin? (Si		10g. Citizen of Wh. U.S.A	American Indian,		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other treumatic event, the Medical Examinat must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces?  1 Yes 2 N No If Yes, Give Year or Dates:	l'	f Yes, specify Cub	an, Mexican, Puerto Specify:	Rican, etc.)	Black, Specify:	White, etc. Black		
within 72 ho ene. than "natu	Completed	15. Decedent's Educ (Specify only highest grade	ation completed) College (1-4or 5+)	(Give life. L	acedent's Usual Occupation if we kind of work done during most of working ie. DO NOT use retired)  Housewife			16b. Kind of Business/Industry  Damestic			
ould be filed within 72 Mental Hygiene. arked other than "natatic event, tru Medic	To Be Co	7th grade 17. Father's Name (First, Middle, Last)  John H. Mills			18. Mother's Nam	Maiden Sumame) ulia A. Joh	<sup>Asiden Sumame)</sup> llia A. Johnson				
1 and 2 should Health and Men Iom 27 is marke		19a. Informant's Name/Relationship (Type Mr. Nicholas J. Hall (S		Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  ountain Ash Court Waldorf, Maryland 20602							
Pages 1 and neut of Healunt: If item		20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Re 1 □ Donation 5 □ Other (Specify)	a	emetery, crer	sition (Name of natory or other pla on Cemetery	May 20		Clinton, M	aryland		
permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service License	, Sie		Name and Addre	ess of Facility I		neral Home n, D.C. 200			
The law requires that the death certificate be executed to be second t	dicai Examiner	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to	pence of);	A Hea	A F	ailun		Interval Between Onset and Death Onset and Death		
that the death certificed by the attending properties as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1						23d. Date of delivery Month Day Year			
quires that the signed by aid be detact	by							3e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ Xlo 3 ☐ Probably 4 ☐ Unknow			
	Completed						24a. Was autoj perfo 1 🗆 Yes	psy pri prmed? de	ere autopsy findings availab or to completion of cause of ath? ] Yes 2 XNo		
ysician: is certific director,	To Be	25. Was case referred to medical examiner? 1 Tyes 2 The No					eath (Check only one)  Home 5 - Residence 6 - Other (Specify)				
Attending Ph r death. actor: After th by the funeral		27. Manner of Death  1 Anatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	nyat vrk? ]Yes 2 □No	28d. Describe how injury occurred				
F Site	Certification:								(Street and Number or Rural Route Number, own, State)		
e Hospital 24 hours a Funeral C	edical										
To the To the Complex	Me	29b. Signature and title of certifier	se number 604(	0		te signed (Month, Dey, Year)					
		30. Name and address of person who co	mpleted cause of death (Item D. 11711 Living	n 23a) (Type, ston Ro	Print) ad Fort Was	hington, M	eryland 2	0744			
St	ate	Amir 31. Date filed (Month, Day, Year) MAY 9 3 2005	39. Registrar's Signa	ature							

		1	State Registrar	,		artment of I rtificate of			Reg. No.	21115	18822	
	 hysicia		1. Decedent's Name (First, Middle, Last)  Catherine Delores Hawkins					2. Date of De	ath 14 Day	05 <sup>Year</sup>	3. Time of Death 18:10р м	
	/Medic	al -	4a. Facility Name (If not institution, give s			4b. City. Town.	or Location of Death			County of Death		
	xamine	er	Prince Georges			Chever		Prince Georges				
	Funeral Director	- 1	5. Social Security Number 6. Sex		s. last birthday, Yrs.	Months Days		8. Date of Bi	rth ay, Year)	9. Birth Cal Wast	place (State or Foreign intry) ington DC	
Maryland	a-t show		Usual Residence of Decedent  10a. State 10b. County  DC		city, Town or L ashing	ton DC					10d. Inside City Limits 1 X Yes 2 ☐ No	
with the	sa or 28	<u> </u>	10e. Street and Number 1249 Eaton Roa	d SE #203		10f. Zip Code 20020			10g. Citi	izen of What Cou A	intry?	
11215-0036 within 72 hours after death with the Maryland	item 27 is marked other than "netural, or items 23s of 28s-1 show other treumetic event, the Madical Examiner must be notified at	by Fur	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	1 ☐ Yes 2 TxtNo		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	ecify Yes or N Rican, etc.)	0-	14. Race - Amer Black, White Specify: b1	, etc.		
<b>21215-0036</b> Id within 72 hours af giene.	n netura Medical I	Completed	15. Decedent's Educ (Specify only highest grade	16a. Dece (Give life.	edent's Usual Occu e kind of work done DO NOT use retire	pation during most of work ed)	ing	16b. Kind of Business/Industry				
d 212 filed withi Hygiene.	er tha	E O	12th	College (1-4or 5+)	dor	mestic			hou	sekeep	ing	
Maryland 2 Id 2 should be filed Ith and Mental Hygi	rked oth	To Be (	17. Father's Name (First, Middle, Last)  John Holt				18. Mother's Name					
2 sho	e muse	d	19a. Informant's Name/Relationship (Ty				and Number or Rura					
e, N 1 and Health	ther to		Deborah King-Co 20a. Method of Disposition			Dansir Osition (Name of	ng Dr.,To	emple Date		1s,MD.		
Jor H	= 5		1X Burial 2 ☐ Cremation 3 ☐ R	amousl from State	cemetery, cre	matory or other pla	na1 5/23				Virginia	
Baltimore, permit. Pages 1 a Department of Hea	Importent: If tem 27 is marked other than eny injury or other treumetic event, ILe M. once.	Ì	4 □ Donation 5 □ Other (Specify)  21. Sign to a of tweral Service icensity		2	2. Name and Addr			-		VIIGINIA	
E			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the de		iter the mode of dy	ng, such as cardiac	or respiratory a	arrest,	20002	Approximate Interval Between	
Phys	ician		Immediate Cause (Final disease or condition					Onset and Death				
/Me	dical niner		resulting in death)	Septic  Due to (or as a conso  Sepsis								
760, te be executed	oran and ourial-transit	Ĭ.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last	Due to (or as a conse								
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Records, P.O. Box 68 The law requires that the death certifica	ed by the attending physician and detached for use as the burial-transit	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Ves 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnant at time of death 5 ☐ Other (special contents)							23d. Date of delivery Month Day Year		
rds, P.	should be deta	d by Pi	Part II. Other significant conditions cor Obesity	tributing to death but not re	esulting in the	underlying cause gi	ven in Part I.		tobacco u		the cause of death?	
Records,	rector, page 2 sho	omplete	Respiratory Failure						s an 24b. Were autopsy findings available prior to completion of cause of death?			
	tor, p	0	25. Was case referred to medical	26. Place of Dea					1   Yes 2   No   1   Yes 2   No			
of Vita	his ce I direc	ToB	examiner? 1 ☐ Yes 2 🛣 No		rsing Home 5 Residence 6 Other (Specify)			ify)				
Duing .	After t funera	Certification;	27. Manner of Death  1 Anatural 5 Pending 2 Accident investigation	( <i>Month, Day Year</i> ) Injury Work? on M 1 ☐ Yes 2 ☐ No				28d. Describe how injury occurred				
affe O	al Director: ad in by the	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe						on (Street and Number or Rural Route Number, Town, State)		
To the Hospitel or within 24 hours after	e Funera	Medical				, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)						
To the within 2	To th	Me	29b. Signature and title of certifier 29c. License number					29d. Date signed (Month, Day, Year)			, Day, Year)	
1			John My	1/h		D00	26024		5/1	7/05		
1 IT	)		30. Name and address of person who co Lester Miles M					_		MD 2078	~ ~	

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrer Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 10 Thomas Ridgaway Hunt Jr. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Solisby (y If Under 1 Year | If Under 24 Hr Months Days Hours Mir eninsula Legional Medical Cente WILDMICO 8. Date of Birth (Month, Day, Year) 12/19/1942 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**√**2 M 2 □ F Months Min 217-40-0714 62 Director Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County item 27 is markad other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Exemples must be notified at 1 ☐ Yes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 801 Outten Rd. 21804 USA death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Plumbing & Heating 6 Plumber 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Thomas Ridgaway Hunt Sr. Mable Louise Hands 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Susan D. Hunt/wife 801 Outten Rd., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State injury \* 4 ☐ Donation 5 ☐ Other (Specify) St.Pauls Cemetery 5/21/05 Marion Station, MD 22, Name and Address of Facility Holloway Funeral Home Professional Association 24 Signature of Funeral Service Licensee Holloway Funeral Home Profeson Solutions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ADUTE COLONGIA /Medical Due to (or as a consequence of): Examiner ASCVD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed DIABGIES use as the burial-tran Due to (or as a consequence of) attending physician P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 🗆 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Alatural Injury 5 Pending after death. Director: Af investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Nah DR. USITA D057359 NATESAN 17/5 2005 May 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISBURY, MD 21804 1415. S. DIVISION 31. Date filed (Month, Day, Year) State MAY 2 0 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** May 18. 2005 8:35am Rachel L. Henry /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Wilson Health Care Center Gaithersburg 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 🖾 F North Carolina Director 91 Aug. 1913 577-60-4869 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County "netural", or Itams 23e or 28a-f show idical Examiner must be notified at 1 No 2 No Directo Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 333 Russell Avenue #220 20877 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "netural; or itams 236 amounts in italy or other traumetic event. The Medical Examinal must ance. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐ Yes 2 🛣 No f Yes, Give 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Research Chemist Federal Government 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Iola Bowling Thomas A. Harris 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 333 Russell Avenue #220, Gaithersburg, MD 20877 (Spouse) John W. Henry 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Metropolitan Crematory 5/18/05 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 23a Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Cereprovascuar Physician disease or condition resulting in death) /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent premant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4☐Pregnant at time of death P.O. the 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 5 ☐ Residence 6 ☐ Other (Specify) 2 1 🗌 Yes this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. М 2 Accident Diractor: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To tha within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie May 2005 cause of death (Item 23a) (Type, Print) 30. Name and address of per-Russell Ave. ( aith ers burg OlinsKy teven 31. Date filed (Month, Day, Year) Registrar's Signature State 19

Registrar

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	State of Maryland / Department of Health and No. 1 - State Amend Item 1 per me G844 6-7-05 tas. Certificate of Death	ental Hygie Reg.	ne 2005	18825
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Examine	4a. Fecility Name (If not institution, give street and number) SOUTH BOUND Rt.495 EAST OF Rt.202  4b. City, Town, or Location of Death LANDOVER		4c. County of Death PRINCE GI	
Funeral Director	5. Social Security Number 219-45-5724 6. Sex 12M 2 F 36 Yrs. 14 Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 3/11/1	gar) Cou	place (State or Foreign intry) X1CO
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72 hours after death with the Maryland natural; or items 23e or 28e-f show dies Examiner must be notified at short by Euraral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1  Never Married 2 Married  1  Yes, Give 1  Yes, Give 1  Yes  2 No		14. Race - Amer Black, White Specify:	
within sne. than	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Chef	ing	Restaura	•
should be filed as marked other umatic event, I	17. Father's Name (First, Middle, Last)  Paul Martinez Peres  Joyi:	e (First, Middle, Mai ta Herre	den Sumame) ra Rodri	guez
27 15 27 15 r tre	19a. Informant's Name/Relationship (Type, Print) Brother Emilio Martinez Herrera/ 19b. Mailing Address (Street and Number or Rur 6846 Riverdale Rd		*	
permit. Pages 1 ar Department of Hea mportant: If Item any injury or othe ance.	20a. Method of Disposition  1 \Remarksurial 2 \Boxed Cremation 3 \Beautyal from State  4 \Boxed Donation f 5 \Boxed Other (Specify)  Comments of Comme		. Location - City or Tuebla, Me	
permit. Departm Importe any inju	21. Signature of European Service Licenses 22. Name and Address of Eacility PHILIP D. RINALD. 9241 Columbia B.	I FUNERA	L SERVIC	CE, P.A.
Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac shock, or hear failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	The second secon		Approximate Interval Between Onset and Death
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lysic lis ce dire	examiner?  Hospital: 1 Innatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Ho	me 5 Residence	e 6 X Other (Speci	by)SCENE
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Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 3:20 A M **Physician** JOHN J. HAmmen ma 2005 /Medical 4a. Facility Name (If not institution, give street and number)
NERTHWEST JOSPITAL LENTER 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE RANDALLSTOWN NORTHWEST If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1**⊠** M 2□ F Months Days Hours Min. Yrs. 216 10 3404 Director Feb 17, 1915 Maryland 90 Usual Residence of Decedent e filed within 72 hours atter death with the Maryland at Hygiene other than "naturel", or Items 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h County d other than "naturel", or Items 23e or 28e-f show event, the Medical Exercited in the national Exercited at 1 ☐ Yes 2 No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 United States 106 Maple Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Mechanical Engineer Space Industry 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H tant: If item 27 Is marked oth Bridget Theresa Kelly John Cornelius Hammen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If item 27 Is eny injury or other treu once. 106 Maple Avenue Catonsville, MD 21228 Mildred D. Hammen/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Pk. 5-24-2005 Elkridge, MD A □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. atth M01044 4112 Old COlumbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION Physician ACUTE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or darking Cause (Disease or injury Due to (or as a consequence of): burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the as 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Ninknown CARDIOMYOPATHY Completed ACCIPENT 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan CEREBROVASCULAR autopsy PAILURE. RENAL 2 X No 1 Yes Division of Vital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Xinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)
MAY 20 Tin 2005 29b. Signature and title of certifler 1 Hy SIGM anil MAY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 RT 1 WEST AVVERAHALLI M HARISH. OLD COURT ROAD 5401 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State Registrar

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Sequentially list conditions; adapting to memorial cause. Enter Underlying Charles along to memorial cause. Enter Underlying Charles along to memorial cause. Enter Underlying Charles along the conditions are consequence of):  Due to (or as a co	ı	/Medical			а.			JNAKI	LIDI	COSTS						
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9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1		certifi iding ise as	/Me		23c. If yes, outcome	e of pregna	incy							23d. Da	te of delive	rv
9   Inknown   9   Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobacco use contribute to the cause of death?   1	B	death atter d for u	Iclar	in the past 12 months?	4☐Pregnant a											•
SO TO	0	t the c by the achee	hys		9□ Unknown											
25. Was case referred to medical examiner?    25. Was case referred to medical examiner?   26. Place of Death (Check only one)   27. Manner of Death   1	Ś	signed d be del	by	Part II. Other significant conditions of	ontributing to death I	but not resi	ulting in the u	nderlying car	use give	n in Part I.						
25. Was case referred to medical examiner?    25. Was case referred to medical examiner?   26. Place of Death (Check only one)   27. Manner of Death   1	cor	w requ	lete									24a. Was	an	24b. 1	Were autop	osy findings available
25. Was case referred to medical examiner?    25. Was case referred to medical examiner?   26. Place of Death (Check only one)   27. Manner of Death   1	Re	he la e has age 2	E G									autor	psy prmed?		death?	
29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29c. Carry Supplied  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	tal		O	25. Was case referred to medical						26. Place	of Death			1	1 1 1 1 1 1	2 140
29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29c. Carry Supplied  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	>	yslcie s cert direct	0 0	examiner?	Hospital: 1 ☐ Inpati	ient 2 🗆	ER/Outpatier	nt 3 DOA	Othe					8 □Oth	er (Specify	')
29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29c. Carry Supplied  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	o uc	ing Phy.		1 XNatural 5 ☐ Pending	28a. Date of Inj (Month, Di	ury						28d. Describe	how injur	y occur	red	
29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29c. Carry Supplied  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	ivisio	iten Jeat tor: the	tificat	3 Suicide 6 Could not b	28e. Place of In	njury - At ho	ome, farm, str		_						er or Rural	Route Number,
(Check only one)  (Check one)  (Check only one)  (Check one		pital o		29a Carifier 1 Carifying Ph				h occurred a	t the tim	e date an	enela be	and due to the	cauco(s)	and ma	nner as st	ated
29c. License number 29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  TONTAL M. CACMANEDA M. D. 1037 S. O.D. O.C. D. C.		4 4 5 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	edica	(Check only 2 Medicel Exar	niner: On the basis	of examina							date and	place,	and due to	the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  TONITAL M. CACMANEDA M. D. 1037 SI OLD OCDAN CUTY BUD. SEXCULIED		Withi To the	Σ	29b. Signature and title of certifier	5	>					_			_		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  EDWIN T. CASTANEDA M.D. 10524 020 8 CEDA CITY BUD. SEXULULUM  State  31. Date filed (Month, Day, Year)  MAY 2 0 2005  32. Pigistrar's Signature		amt		cen	0				D40	025	+		5	7/6	105	
State 31. Date filed (Month, Day, Year) 32. Digistrar's Signature	2	IVA		· ·	TA M D	death (Item	23a) (Type,	Print)	00	<u>^</u>	10	cry 6	3000	). ( <sup>3</sup>	EKLU	CONF
Registrar IVIA1 & V 2003   Deliver 15 Grade				31. Date filed (Month, Day, Year)	005 32. Pgist	trar's Signa	iture	( v .								C10 /

			1 - For Stete Registrar	State of N	laryland /		artment of H		nd M		giene Reg. No.	UUJ	18829
	0		1. Decedent's Name (First, Middle, Las	t)						2. Date of De Month			3. Time of Death
	Physici /Medio		James M. Jenkin	s, Sr.						May	18,	2005 Yeer	12:14A. M
	Examir	er	4a. Facility Name (If not institution, give Laurel Regional He		r)		4b. City, Town, or Laurel	Location of	Death			County of Dea	th George's
	Funeral Director		3/3-34 12/1	x 7. / X M 2□F	nge (In yrs. last b 77	virthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Bir (Month, Da Feb. 18	th ly, Year) , 192	_   00	thplace (State or Foreign ountry) Shington, D. C
	a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince G	eorge's	10c. City, To		ark						10d. Inside City Limits  Yang 2 □ No
	th with the 23e or 28 Ist be no	ai Director	3527 Marlborough	Way			10f. Zip Code 20	740			_	zen of What Co ed Stat	
980	d within 72 hours after death with the Maryland Jiene. r then "naturel", or Items 23e or 28e-1 show the Marical Exe officer and be mufffed at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	12. Was Deceder Armed Force 1 X Yes 2 [ If Yes, Give Year or Dates			Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origi n, Mexican, Specify:	n? (Spe Puerto i	cify Yes or No Rican, etc.)		14. Race - Ame Black, Whit Specify:	
21215-0036	within iene. 'then'	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4o	r 5+)	(Give life. l	tent's Usual Occupa kind of work done o DO NOT use retired Intant	ation furing most ( )	of workir	ng	16b. Kir	nd of Business	•
Maryland 2	e filed al Hyg othe vent,	To Be C	17. Father's Name (First, Middle, Last) David Evans Jenki	ns						(First, Middle,		Sumame)	
	and 2 should list and N 27 is male trauma		19a. Informant's Name/Relationship (7 James M. Jenkins,	,			g Address (Street a						Zip Code) Land 21104
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If itsm 27 Is marked eny injury or other traumatic e once.		20a. Method of Disposition  1  Burial 2  Cremation 3  4 Donation 5  Other (Specify		cemet	ery, crer	sition (Name of natory or other place tan Crema			)/2005		<sub>cation</sub> - City or <b>xandri</b> a	Town, State , Virginia
Balt	permit. Departitimport		21. Signature of Funeral Service Licens	myero	X	44	Name and Address nald V. I 00 Powder	: Mill	_Roa	<u>ad Beit</u>	SV11.	me, PA le, Mar	yland 20705
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Pneumor	nia		er the mode of dying	g, such as ca	ardiac o	respiratory a	rrest,		Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to minediate	Renal	s a consequence Insuffi s a consequence	cien	су						
,8760,	cate be executed physician and the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C.	y Arter		sease						
.O. Box 6	death certifi e attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 □ Fetal deat at time of death		Ectopic pregnancy Other (specify)				2	23d. Date of del Month	ivery Day Year
rds, P	es gu	by	Part II. Other significant conditions co	ntributing to death	but not resulting	in the u	nderlying cause give	n in Part I.			obacco us Yes 2 💆		the cause of death?
Il Records,	The law ate has b page 2 sl	Completed							-	24a. Was autop perfo 1  Yes		prior to death?	topsy findings available completion of cause of
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	100		(Check only o			
of		ion: To	27. Manner of Death  1 X Natural 5 Pending	1 ☐ Inpa 28a. Date of In (Month, £	jury 28b.	utpatien Time of Injury	28c. Injury Work	at Nuis	2	e 5 🗌 Resid 8d. Describe t		i □Other (Spec occurred	cify)
Division	I or Attending after death. Director: After I in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of I	njury - At home, i atc. <i>(Specify)</i>	farm, str	eet, factory, office	-5 2 LIN	-	8f. Location (S City or Tov	Street and vn, State)	i Number or Ru	iral Route Number,
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director:	edical C	29a. Certifier 1X Certifying Phy (Check only one) 1	rsicien: To the besiner: On the basis and manner:	of examination a	ge, death	occurred at the tim restigation, in my op	e, date and inion, death	place, a occurre	nd due to the d at the time,	cause(s) a	and manner as place, and due	stated. to the cause(s)
)	To the i	Me	29b. Signature and title of certifier	ukrei	4		29c. License D005	number 52075				signed (Montley 19, 2	
R	(6)		30. Name and address of person who depended to the second	ompleted cause of • 14201 I	death (Item 23a)	(Type, ark	Print) Dr., #223	Laur	el,	Maryla	nd 20	0707	
•	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 4 2005	■2. Regis	trar's Signature								

			1 - For State Registrer	State o	of Marylar		artmen <i>tificat</i>			and Mer	, ,	ene g. No.2	105	188	30
*	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Las     MARY ANN JOHNSO     4a. Facility Name (If not institution, give	N	mber)		4b. City,	Town, or	Location of	N	Date of Death Month IAY	Day 17,	Year 2005 by of Death	3. Time of Dea	M M
	Funeral Director		8328 WOODYARD R 5. Social Security Number 6. Se 267 94 2200		7. Age (In yrs.	last birthday) 52 Yrs.	If Under Months	CLIN' 1 Year Days	FON If Under	Min.	Date of Birth (Month, Day,	Year)	9. Birthol Coun	ORGES ace (State or Fo try) ORGIA	oreign
	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "neturel", or Items 23a or 28e-f show or other treumatic event, it s. Marila. Exerting the natified at	Funeral Director	Usual Residence of Decedent           10a. State         10b. County           MARYLAND         PRINCE           10e. Street and Number         8328 WOODYARD ROA	D	S C1	y, Town or Lo	10f. Zip	2	20735			UNIT	What Coun	TES	
21215-0036	72 hours after de "neturel", or Items	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed XX Divorced  15. Decedent's Ed	Armed For 1 Yes If Yes, Gin Year or Ducation	VO	16a. Deced	l □ Yes I	No No Il Occupa	Specify:	gin? (Specify , Puerto Rica t of working		Speci	ack, White, e fry: BLA Business/Ind	CK	
	ld be filed within ental Hygiene. ked other than ic event, tre Ma	To Be Completed	Elementary/Secondary (0-12) 1 2 TH  17. Father's Name (First, Middle, Last) JOHN WILLIE ELLIS	College (	1-4or 5+)		DO NOT us		ERATO 18. Mothe		irst, Middle, M		PRIVAT	E	
Baltimore, Maryland	t. Pa rtmen rtent:	-	19a. Informant's Name/Relationship (7  ARYTHA DOZIER / D  20a. Method of Disposition  XXBurial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify  21. Signature of Finital Service Intern	ype, Print) AUGHTEI Removal from	State 20b. F	8328 Place of Dispo cemetery, cren	WOOD!	YARD ne of ther place IETEI	ROAD P)	CLI Date	oute Number,	MD 207 0c. Location HALLEN	735 - City or To	wn, State	
B	Pnysician /Medical Examiner	Examiner	23a. Part 1 Enter the disease, or compand of the property of t	aMET  Due to	caused the deat each line.  FASTATI( (or as a consequence) (or as a consequence)	h. Do not ente BREAS quence of):	or the mod	JITLA e of dying	AND R	OAD	SUITLA	ND, MI	2074	6 Approximate Interval Between Onset and Deat 5 YEAR:	th
.O. Box 68760,	the death certificate be executed y the attending physician and tched for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d. 23c. If yes, ou 1∐Live t	(or as a consequence of pregnation of pregnation of pregnation of down	ancy Il death 3	Ectopic pr						ate of deliver	ry Day Year	
s, P	The law requires that the de ate has been signed by the a bage 2 should be detached f	by	Part II. Other significant conditions co	ntributing to d	eath but not res	ulting in the ur	nderlying c	ause give	in in Part I.			XX No	3 🗌 Proba	e cause of death	nown
Vital Record		Be Completed	25. Was case referred to medical examiner?	3							autopsy performe 1 ☐ Yes X heck only one	ed? X No	prior to con death? 1 Yes		of
of	ding Afte fune	atlon: To	27. Manner of Death  XXNatural 5 Pending 2 Accident investigation	28a. Date (Mon		ER/Outpatien 28b. Time of Injury		8c. Injury Work	at	28d.	XX Residen Describe how			)	
Division	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director:	al Certification:	3 Suicide 6 Could not be determined	build		y) wledge, death	occurred	at the tim		d place, and	City or Town,	State) use(s) and m	nanner as sta		
1	To the Hospitel or within 24 hours after To the Funerel Dir. completely filled in It.	Medical	29b. Signature and title of certifier  30. Name and address of person who certifier	iner: On the band man	pasis of examina iner stated.	yon and/or inv	restigation,		number		at the time, dat	e and place,		the cause(s)	
	Sta Registr		DENNIS A. PRIEBA 31. Date filed (Month, Day, Year) MAY 2 3 2005	Γ,M.D.	Registrar's Signa	110	IRVI	IG SI	C. NW	WAS	HINGTO	N, DC	20010		

DHMH 17 Rev 1/2001

**ORIGINAL** 

		4	For	State of Maryland	•	rtment of He			- ZUII!	18832
			State Registrar  Decedent's Name (First, Middle, Last)		Cel	illicate of D	/calli	2. Date of Death	. No.	3. Time of Death
	Physicia /Medic			LIZABETH JO	OHNSO	N		May 15	Day 2005	
	Examin		a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or l			4c. County of Dea	ath
			Shady Grove Adv			Rockv.	ille If Under 24 Hrs.	8. Date of Birth	Montgo	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. las M 2 S F 72	Yrs.	Months Days	Hours Min.	Feb. 5, 1	933 Ma	irthplace (State or Foreign Sountry) ryland
			214-36-9713  Usual Residence of Decedent							
	filed within 72 hours after death with the Maryland Hygione. that than "natural; or itams 23a or 28a-f show ant, it a Medical Examiner musi to indiffed at	<u>.</u>	10a. State 10b. County	-	Town or Loc	sville				10d. Inside City Limits 1 ĀYes 2 ☐ No
	he Ma	by Funeral Director	MD Montgom	er À L	реатт	10f. Zip Code		100	. Citizen of What 0	
	with t	급		lla Dond		2083	0	109	U.S.A.	
	ns 23	era	19901 Beallsvi	2. Was Decedent Ever in U.S.	13. V	Vas Decedent of His Yes, specify Cuban		ecify Yes or No-	14. Race - Am	nencan Indian,
9	after or ital	Fur	Never Married 2☐ Married	Armed Forces? 1 □Yes 2 ĒNo If Yes, Give		Yes, specify Cuban  ☐ Yes 2 No	Specify:	rican, etc.)	Black, Wh	
003	ural',	d by	3 Widowed 4 Divorced	Year or Dates:				16	Sb. Kind of Busines	
21215-0036	n 72 i	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	ent's Usual Occupa kind of work done d OO NOT use retired)	uring most of work	ing	Montgom	ery Co.
212	y with	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Bus	Operato	r		Public	Schools
g	e filec al Hyg fotha vant,	Be C	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma	ŕ	
ylaı	Ment Ment arked arked	2	Morris Fish					thel Mo		
Maryland	12 sh hand 7 is m Iraum		19a. Informant's Name/Relationship (Typ. Linda Smith- Da			g Address (Street a				,MD 20839
O	1 and Healt Iam 2		20a. Method of Disposition	_		sition (Name of natory or other place		1 11 -	c. Location - City of	
E E	Sage Hand		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	miovai iiom State		UMC Cem		/2005	Poolesv	ille,MD
Baltimore,	perriit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depirtment of Health and Mental Hygiene. Important: if Item 27 is marked othar than "natural; or Items 23a or 28a-f show among the remaining the profiled at any intry of othar traumatic event, the Medical Examiner must be published at annex.		21 Igna re of Funeral Service Licens	4-4		. Name and Address	s of Facility Sn	owden F	uneral	Home, P.A.
8	8 9 E 8 9		seeaso f	snoegher	N					le, MD20850
			23a. Part1. Enter the disease, or complice shock, or heart ailure. List only on	ations that caused the death. e cause on each line.	Do not ente	er the mode of dying	, such as cardiac	or respiratory arres	it,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Myou		dial	forta	action		1 hour
	/Medical Examiner			Due to (or as a c/nseque	,					i de
0	1997	ie.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of	110				477763
	cuted	Examiner	that initiated events							
ó,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a conseque	ence of):					
68760,	physic the b	dlcal	d							7
9 X	death certificat e attending phy d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregnan					23d. Date of d	lelivery
Box	death a atter d for u	Iclar	in the past 12 months?	1 Live birth 2 Fetal of 4 Pregnant at time of dea		Ectopic pregnancy Other (specify)			Month	Day Year
P.0	t the by the lache	hys	9 □ Unknown	9□ Unknown						
Ś	Se us	by	Part II. Other significant conditions con	tributing to death but not resul	ting in the u	nderlying cause give	n in Part I.	23e. Did toba 1 ☐ Yes		to the cause of death?  Probably 4 Sunknown
Record	requires een sign hould be	ompleted								
Jec	e lav has e 2	mpl						24a. Was an autopsy performe	prior to agl/? death'	
Vital		e Co	25. Was case referred to medical				26 Place of Deat	1 ☐ Yes →2	No 1 Ye	es No
Ž		0 8	avaminer?	ospital: 1   Inpatient 2   E	R/Outpatien	t DOA Othe	AP1		ce 6 Other (Sp	pecify)
n of		T :uc	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	at ?	28d. Describe how	v injury occurred	
sio	at to a	catl	2 Accident investigation 3 Suicide 6 Could not be				res 2 □No	Of Location (Com	at and Number or	Rural Route Number,
Division	or Attandite death	Certification:	4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, tarm, str	еві, тасіогу, опісе		City or Town,		nurai noute Number,
_	Hospital	alC	29a. Certifier Certifying Phys	ician: To the best of my know	rledge, deatl	n occurred at the tim	e, date and place,	and due to the cau	use(s) and manner	as stated.
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	edical	(Check only 2 Medical Examit	ter: On the basis of examination and manner stated.	on and/or in					
	To tha within 2 To tha complet	Σ	29b. Signature and title of certifier			29c. License			d. Date signed (Mo	
	5		Futt Then	M. 11-	00-1 =	US	(780	10	dy 15	, 2005 md 20850
	•		30. Name and address of person who	9901 Ms	Local	Print)	- Drie	e Run	K. 11.	MJ 20850
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signate	ure	- 144 R	1//	- 1-00	-ville,	0.00
	Regist		MAY 1 9 200	32 Registrar's Signatu	190					

		ŀ	for State Registrar	State of Ma	aryland /	-	artment <i>tificate</i>			nd M	ental Hy	giene Reg. No		)	8833
	Dhuniai		1. Decedent's Name (First, Middle, Las								2. Date of De	eath Da	y Ye		3. Time of Death
	Physici /Medic		KATHLEEN M.	JOYCE							May	17,	2005		12:40 A <sup>M</sup>
}	Examin		4a. Facility Name (If not institution, give				4b. City, T	own, or	Location o	f Death		40	. County of D	eath	
			Suburban Hospital				Beth						ontgom	ery	
	Funeral		5. Social Security Number 6. S 217–19–2282	ex 7.Age □M2∏XF	34 (In yrs. last i	birthday) Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da	th ay, Year)	9.	Birthplac	ce (State or Foreign
ķ,	Director		Usual Residence of Decedent	- K	J4	113.					July 2	3,19	70 Ca	alif	ornia
	land ow		10a. State 10b. County		10c. City, To	own or Lo	cation							10d	I. Inside City Limits
	Many -fsh Iied	to	Md. Montgom	nery	Silve	er Sp	ring								1 ☐ Yes 2 🕅 No
	r 28e	irec	10e. Street and Number				10f. Zip (	Code				10g. Cit	izen of What	t Country	/?
	th with	Funeral Director	12002 Dewey Road				2	0906	5			Uni	ted St	ates	3
	ems ems	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. V	Vas Decede	ent of His	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)	)-	14. Race - A	merican Vhite, etc	
36	or It	y Fu	1 XNever Married 2 Married	1 ☐ Yes 2 📉 N If Yes, Give	lo	1	Yes 2		Specify:	, r donto i	110011, 010.7		Specify: W		
8	72 hours after death with the Maryland neturel', or Items 23a or 28e-f show dical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:	1										
15-	"net	Completed	15. Decedent's Ed (Specify only highest gra		16	(Give	lent's Usual kind of work DO NOT use	done di	urina most	of worki	ng	16b. K	ind of Busine	ess/Indu	stry
12	withi ene. than	шc	Elementary/Secondary (0-12)	College (1-4or 5-		None	70 110 1 430	3701700)				No	ne		
D	filed Hyg other ent,	9	17. Father's Name (First, Middle, Last)		1	_			18. Mothe	r's Name	(First, Middle	, Maider	Sumame)		
ylan	Mental Mental arked atic ev	To B	William J. Joyce						Fra	nces	L. Tho	ompso	on		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (** Frances L. Joyce				g Address (				Route Numb				
	Hea Hea tem 2		20a. Method of Disposition	(Mochel)			sition (Name natory or oth			D	er Spri		cation - City		
0H	ages ent of		1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify				leaven			May 2		Silv	er Sp	ring	. Md.
Baltimore,	mit. I		21. Signature of Funeral Service Licen		1		. Name and			,					,,
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Н	*		23a. Part1. Enter the disease, or companies shock, or heart failure. List only	plications that caused one cause on each lin	the death. Dee.	o not ente	er the mode	of dying	, such as o	cardiac o	r respiratory a	rrest,		In	pproximate hterval Between Inset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Cardiac											miget and Death
	/Medical Examiner		Tosuming in death)	Due to (or as a											
		- G	Sequentially list conditions, if any, leading to immediate	b. Chronic Due to (or as a											
	uted Insit	min	Cause (Disease or injury		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,										
Ć.	execu in and ial-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	a consequenc	ce of):								_	
8760,	death certificate be executed e attending physician and id for use as the buriat-transit	icai		. d.											
9	ing ph	Med	IF FEMALE:												
Вох	eath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 Fetal dea		Ectopic pre						23d. Date of Month	delivery Da	ay Year
0		Physician/Med	1 ☐ Yes 2 🛣No 9 ☐ Unknown	4□Pregnant at t 9□ Unknown	time of death	5 ∟	Other (spe	city)				- 12			,
<u>α</u>	that the ed by detail		Part II. Other significant conditions of	ontributing to death bu	it not resulting	g in the un	iderlying cai	use giver	n in Part I.		23e. Did t	obacco (	ise contribut	e to the	cause of death?
Records,	requires that the een signed by th nould be detache	d by	Respirator Use								1 🗆	Yes 2	<b>_X</b> No 3	] Probab	ly 4 □Unknown
CO	> 0 10	lete									24a. Was	an	24b. Were	autopsy	/ findings available
	0 5 0	Completed										rmed?	prior	to comp	letion of cause of
Vital	icien: Th certificate ector, paç	0	25. Was case referred to medical						26. Place	of Death	(Check only of	2 X No	1 1 1	/es 2[	
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n of			27. Manner of Death	28a. Date of Injury (Month, Day	y Year) 28b	. Time of Injury	28	c. Injury	at ?		8d. Describe				
Siol	Attending r death. ector: After by the fune	atic	2 Accident investigation	1		,,	М		es 2 🗆 N	lo					
Division	or Att	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, . (Specify)	farm, stre	eet, factory,	office		2	8f. Location (. City or To	Street an wn, State	d Number or )	Rural R	loute Number,
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	To the within 2 To the complet	Me	29b. Signature and title of certifier	0//		jun .	29c.	License	number			29d. Da	e signed (Mi	onth, Day	y, Year)
			12	~ //长			M	D171	37			May	17, 20	005	
	3		30. Name and addre of pe son who	completed cause of de	eath (Item 23a	a) (Type, F	Print)							-	
			Dr. Bruce Rind M.					1 Rd	. De	rwoo	od, Md.	208	355		
to	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 0 2	005 32 legistra	r's Signature	An	uke								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Regist HEND TIEM #5 PER FH C846 8/22 Milicate of Death 2. Date of Death 3. Time of Death Month May 20, **Physician** 2005 Smith Kissinger 2:25A Kathryn /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Civista Medical Center LaPlata Charles If Under 1 Year | If Under 24 Hrs. Months Days | Hours | Min 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F 90 Oct. Washington Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ..." any injury or other traumatic events. 10c, City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 ☐ Yes 2 🌠 No Director MD Charles Waldorf 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20601 70 Village Dr., #206 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Administrative Assistant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Nellie Alma McCrory John Bender Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) John Kahler - Friend 16302 McKendree Rd., Brandywine, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Trinity Mem. Gardens \ 05-26-2005 \ Waldorf, MD Name and Address of Facility Huntt Funeral P.O. Box 156, 21. Signature of Foneral Service Licensee M01391 Home Waldorf, MD Approximate Interval Between Onset and Death Do not enter the mode, of dying, such as cardiac or respiratory arrest, 23a. Parti. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a co for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Dav in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 1 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 2 25. Was case relerred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home Hospital: Inpatient 1 🗌 Yes 2[ 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To his Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death
Director: / 6 Could not be determined 3 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 | Homicide of 24 hours.
The Funerel Directory filled in Ecritifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated within 2 To the Bate signed Month, Day, Year) 29b. Signature and 29c. License number D-0060181 30. Name and address of person who completed cause of death (Item 33a) (Type, Print) Stacie Gump, MD 12070 Old Line Ctr Ste 202 Waldorf, MD 20602 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

P.O. Box 68760,

Division of Vital Records,

2005

Peter Lynn Kidwell Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-3435 State of Maryland / Department of Health and Mental Hygiene For Stata Ragistrar AKG Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** P M May 17 2005 8:49 PETER LYNN KIDWELL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Southern Maryland Hospital Center Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax **Funeral** 1<del>√</del> M 2□ F Months Days Hours 220-74-8757 45 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 28a-f ahow the Medical Exerciner must be notified at 1 ☐ Yes St☐ No Directo Maryland Charles Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 3215 Malcolm Road Itams 23a 20613 by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Construction Handyman 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If itam Z7 is marked oth, any injury or other traumetic event, once. 17. Father's Name (First, Middle, Last) Be Betty Kidd Linkins Charles L. Kidwell P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3215 Malcolm Road Brandywine, Maryland 20613 Dawm M. Kidwell (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 72 □Cremation 3 □Removal from State 1 Buria Metropolitan Crematory 5-21-05 Alexandria, VA Other (Specify) 4 Donation 21. Sign 22. Name and Address of Facility Eberwein Funeral Services M00173 4433 White Pls. La. White Pls., MD 20695 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** Due to (o as a obsequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (clistate of hijury) Due to (or as a consequence of): Examiner use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Causa (Discass of that initiated events attending physician and resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No ō 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð eq 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 XYes 2 \sum No 24a. Was an certificate has autopsy performed? ¥Yes 2□No funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 patient 2 ER/Outpatient 3 DOA 1 XYes 2 No Certification: To his 28b. Time of Injury 28a. Date of Injury (Month, Day 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After subject hanged self 5 Pending 1 Natural 1 ☐ Yes 2 🕱 No investigation ☐ Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after death Director: 6 Could not be determined 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 13400 Dille Dr, Upper Maribaru, cell cul 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 区域edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one)

State Registrar

2 Greenberg M.D Tasha 31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

111 Penn Street Baltimore Maryland 21201

29d. Date signed (Month, Day, Year)

May 18, 2005

- MD

and manner stated.

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29c. License number

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	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of Dea	h	4c. Cou	inty of Death	
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п	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. II	ast birthday) Yrs.	Months Days	Hours Min		rn 1 <i>y, Year)</i> 7 <b>,</b> 192!	9. Birthp Coun	lace (State or Foreign try) Yland
			215 22 0696 Usual Residence of Decedent					Journe /	1.72.	J Man	утана
	how	L	10a. State 10b. County	10c. City	, Town or Lo	cation				1	Od. Inside City Limits
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á		Certi	4 Homicide	building, etc. (Specify	<i>'</i> )			City or To	wn, State)		
	To the Hospital or within 24 hours afte To tha Funaral Dit completely filled in	edical (	29a. Certifier Certifying Phys	sician: To the best of my knowner: On the basis of examinat	wledge, death	occurred at the til	me, date and place	e, and due to the	cause(s) and	d manner as st	ated.
	To the H within 24 To tha F complete	Medi	one)	and manner stated.							
	To To		29b. Signature and title of dertifier	. ~		29c. Licens				gned (Month, i	
7			30. Name and address of person who co	M ()	23a\ /Tupe		5-000	) ,	MAY	20, 2	21287
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	98	ру Р	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.			ontribute to the cause	1/
ord	w require been si should I	eted			-	Yes 2□No		4 Unknown
Records,	The law ate has page 2 s	Completed				rmed?	<ul> <li>b. Were autopsy find prior to completion death?</li> </ul>	n of cause of
Viital		Φ	25. Was case referred to medical	26. Place of Dea	ath (Check only o	2 □ No □	1 Yes 2 No	
of <	Physician: this certificanal director,	ToB	examiner? ¹XYes 2 ☐ No Hospital: 1 ☐ Inpatient 2 X EP/Outpatier					
	ding P. h. After t funera	ion:	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  28b. Time of Injury (Month, Day Year)	f 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe	now injury oc	curred	
Division	deat ctor: y the	ertification:	3 ☐ Suicide 6 ☐ Could not be				mber or Rural Route	Number,
Ö	ital or A rs after ral Directed in by	Cert	4 Homicide building, etc. (Specify)		City or To	vii, State)		
	To the Hospital or within 24 hours after To the Funeral Difficompletely filled in	edicai	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, deat 2 XMedical Examiner: On the basis of examination and/or in and manner stated.					use(s)·
	Vithin 2	Med	29b. Signature and title of certifier	29c. License number		_	ned (Month, Day, Ye	ear)
)			Hate bronica-tollale	OCME		June 1	L, 2005	
			30. Name and address of person who completed cause of death (item 23a) (Type,	Print) 111 Penn Street	Baltir	nore. N	Marvland 2	1201
	Sta	te	31. Date filed (Month, Day, Year) 32. Distrar's Signature	4		-, -	J	
	Registr		JUN 0 6 2005	and a				
DH	MH 17 Rev 1/2	001	2222	-				

			1 - For State Registrar		Department of Health and Certificate of Death		ne No2005 18830
	Physici /Medic		1. Decedent's Name (First, Middle, La Stanley	Lester		2. Date of Death Month	Day Year 3. Time of Death 3. 38 AM
	Examir Funeral	er	4a. Facility Name (If not institution, given Doctors Commun  5. Social Security Number 6. S		4b. City, Town, or Location of Dea  Lanham  birthday) If Under 1 Year   If Under 24 Hi	rs. 8. Date of Birth	4c. County of Death  Prince Georges  9. Birthplace (State or Foreign
	Director		578-20-6666  Usual Residence of Decedent  10a. State 10b. County	15€ M 2□F 82	Yrs. Months Days Hours Min	n. (Month, Day, Ye	1922 Wash.,DC
	the Maryla 28a-f shor	rector	Md. P.G.		er Marlboro	10a.	10d. Inside City Limits 1 ☑ Yes 2 ☐ No Citizen of What Country?
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If them 27 is marked other then "neturel", or Items 23e or 28e-f show or other treumetic event, It is Madical Examiner must be notified at	Funeral Director	5605 South Mar 11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No		U	Inited States  14. Race - American Indian, Black, White, etc.  Specify: -
	hin 72 hours t. in "neturel", Medical Exe	Completed by	3 Widowed 4 Divorced  15. Decedent's E (Specify only highest gr  Elementary/Secondary (0-12)	Year or Dates: 1945	6a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)	orking 16t	Black D. Kind of Business/Industry
	3.2 should be filed within h and Mental Hygiene. 7 is marked other then " freumetic event, Ir a Mac	Be	12 17. Father's Name (First, Middle, Last	)		ame (First, Middle, Mai	·
•	and 2 should lealth and Men m 27 is marke her treumetic	То	Richard Leste  19a. Informant's Name/Relationship ( Bertina Lester)	Type, Print) 1	Cathe 9b. Mailing Address (Street and Number or F 5605 South Marwoo	Rural Route Number, Ca	rren ity or Town, State, Zip Code) # 4 4 1
•	ry are Pa		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special Control of	Removal from State Cemeral (y) Md.	Upper Marlboro, II of Disposition (Name of tery, crematory or other place) Veterans Cem. 5/2	7/05 Ch	e. Location - City or Town, State
	permit. Departn Importe eny inju		21. Signar re of Funeral Service Lice	Levards	<del>-   </del>	l Rd., Su	Edwards F.H. uitland, Md. 20746
	Physician /Medical Examiner	Examiner	Shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any 1 sector of the cause. Enter Underlying Cause (Disease or injury that initiated events	a Due to (or as a consequence	EPSIS		Interval Between Onset and Death
	icate be executed physicien and stransit transit	dlcal	resulting in death) Last	Due to (or as a consequence d.	ee of):		
	The law requires that the death certifics tile has been signed by the attending pt aage 2 should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown	tth 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
	w requires that been signed t should be deta	by		contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?  2 \( \text{No} \) 3 \( \text{Probably} \) 4 \( \text{M}\)Unknown
		Completed				24a. Was an autopsy performed	
	a or Attending Physicien: after death. I Director: After this certific d in by the funeral director.	Certification: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigatio 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At home,	Outpatient 3 DOA Other: 4 Nursing  5. Time of Injury M 1 Yes 2 No	Home 5 Residence 28d. Describe how in	njury occurred t and Number or Rural Route Number,
	4 hours a unerel lely filled	edical Cert	29a. Certifier / Certifying Ph	building, etc. (Specify)  sysician: To the best of my knowled niner: On the basis of examination	ge, death occurred at the time, date and plac and/or investigation, in my opinion, death occ	City or Town, Si	a(s) and manner as stated
:	vithin 24 To the F complete	Med	29b. Signature and title of certifier	and manner stated.	29c. License number	29d.	Date signed (Month, Day, Year)
1	1) Wa		30. Name and address of person who	completed cause of death (Item 23a	DOSS 2 1) (Typo, Print) . 4203 QUEENS BUR	11 28 HU	10 TTSV(418 MD 278)

		State of Maryland / Department of H  1- State Certificate of L			2000	10000
		1. Decedent's Name (First, Middle, Last)	Jean	Reg.	No. UU	3. Time of Death 4
Physicia	an			Month	Day Year	12.50 M
/Medic	al	Willis Drake Lancaster  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or	r Location of Death	MAY 18	4c. County of Death	12.50
Examin	er		Washin	do	Prince	Comes
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9	lace (State or Foreign
Funeral Director		096-36-0191 1⊠M 2□F 57 Yrs. Months Days	Hours Min.	8. Date of Birth Month, Day, Ye March 8	, 1948 Cour	IX
		Usual Residence of Decedent				
nylan how		10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
e Ma	ct	Md. P.G. Fort Washington	1			M∏Yes 2 ☐ No
or 28	Dire	10e. Street and Number 10f. Zip Code			. Citizen of What Cour	
be filed within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland fall hygiene. It has a fall hygiene do then than "natural", or items 23s or 28s-f show event, it has Madical Evanians must be notified a search.	Funeral Director	11910 Autumnwood Lane 2074			United St	
er de tems	nue	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of H if Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	Pican, etc.)	14. Race - Americ Black, White,	
s after	by F	1 □ Never Married 2 \( \overline{\o	Specify:		Specify: Bla	ck
within 72 hours after ene. than "natural", or ite		15 Decedent's Education 16a, Decedent's Usual Occup.	ation	161	b. Kind of Business/In-	
in 72	Completed	(Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired	during most of work	king		,
with than the	mo	Elementary/Secondary (0-12) College (1-4or 5+)  **A Mortgage Le	nder	Se	elf-Emplo	yed
filed Hygid other ant, t	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Mai	iden Sumame)	
IZITO Jid be fill fental H rked oth lic evan	To B	Edward Lancaster	Paulin	e Miller		
2 should and Me ls mark	,-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street 11910 Autum			ity or Town, State, Zip	Code)
and 2 and 2 ealth in m 27 I		Ruth A. Lancaster/wife Fort Washin	gton, M	aryland		
		20a. Method of Disposition  1   20b. Place of Disposition (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 200	c. Location - City or To	own, State
Daltimor permit. Pages: Department of th Important: If ite any injury or of		'4 □Donation 5 □Other (Specify) Resurrection C	em 5/2	3/05 C	Clinton,	Md
Dall permit. Departr Importa any inji		21. Signature of Funeral Service Licensee 22. Name and Addres	ss of Facility H	odges &	Edwards	F.H.
D 20 E 20					uitland,	
W. W.		23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin shock, or heart failure. List only one cause on each line.	ig, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
Physician			· dis Vts	cular H	eart Dis	Carlo Dealin
/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
Lxammer	_	Sequentially list conditions,  Due to lor as a consequence of:				
ed sit	Examiner	cause. Enter Underlying Cause (Disease or injury			-	
xecul and al-trar	xan	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
8 / 6U, ate be executed hysician and the burial-transit						
	edlcal	d.				
COIdS, P.O. BOX 08/00, wrequires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	ery
d for	icial	in the past 12 months?  1 □ Ves 2 □ No.  4 □ Pregnant at time of death 5 □ Other (specify)	/		Month	Day Year
t the c	hys	9 Unknown			1	
ecords, r. law requires that as been signed b 2 should be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.	23e. Did tobac	cco use contribute to the	ne cause of death?
w require	ed t	PIAbels		1 ☐ Yes	2 □ No 3 □ Prob	pably 4 Honknown
law re as bee	Completed			24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
n e h e age	шо			performe	d? death? 1 ☐ Yes	
VITAL Ician: T certificat ector, pa	a	25. Was case referred to medical	26. Place of Dea	th (Check only one)		
Of VITA Physician: rithis certific ral director,	To B	examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	ner: 4 🗆 Nursing Ho	ome 5 ☐ Residenc	e 6 Other (Specif	y)
on or ding Phys		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury 1 □ Natural 5 □ Pending (Month, Day Year) Injury Wor	y at rk?	28d. Describe how	injury occurred	
andir aath. or: Af	atic	2 Accident investigation M 1	Yes 2 □ No			
DIVISION  I or Attanding after death.  Director: After tin by the fune	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,
ral Diffed ir						
Hosp 4 hou Fune ely fil	ical	29a. Certifier  (Check only (				
UNUSION To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	one) and manner stated.  29b. Signature and title of certifier 29c. Licens	se number	204	. Date signed (Month,	Day, Year)
To Viit		200. Digitality and in or solution	176-			_
		Haron 19 NO NO	050 77	-/ /	2003 22	709)
(5)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  54 (va dor Sylvaller, 2001 Hospital)	Drine	CP - 1	may 23,	land
Sta	to	31. Date filed (Month, Day, Year)  22. Registrar's Signature	41110		1 marry	- 12
Registr		MAY 2 4 2005 Keeter, & franks				

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / De	partment of Health and N	•	•	10010
			Registrar	ertificate of Death		1. No. ( U U )	10041
	Physici /Medic		Decedent's Name (First, Middle, Last)     MARY	LUCAS	2. Date of Death Month MAY 18	3 2005 Year	3. Time of Death 22:45 P M
	Examin		4a. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL	4b. City, Town, or Location of Death CHEVERLY		4c. County of Death PRINCE GE	ORGES
	Funeral Director		5. Social Security Number  248-32-5865  6. Sex 1 M 2 TF  7. Age (In yrs. last birthda 91  Yrs.	y) If Under 1 Year   If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, ) August 4	(ear) 9. Birthp Cour 1913 SOUT	lace (State or Foreign try) H CAROLINA
	yland		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		1	0d. Inside City Limits
	the Mar 28a-fs	Director	MD PRINCE GEORGE'S LARGO	10f. Zip Code	100	. Citizen of What Cour	1∭Yes 2☐No
	3a or	i Di	1007 FENTON PLACE	20774		USA	,
	death	Funerai		B. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No-	14. Race - Americ	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Ever in an most be rediffed at once.	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	nican, etc.)	Black, White, Specify: B1	ack
215-0	thin 72 ho e. an "natu	Completed by	(Specify only highest grade completed) (Gi	cedent's Usual Occupation we kind of work done during most of work DO NOT use retired)	ing 16	b. Kind of Business/Ind	dustry
7	ed wii	Con	3rd	DOMESTIC		PRIVATE	
Maryland 21215-0036	ould be fil Mental H arked ott atic even	To Be	17. Father's Name (First, Middle, Last) EVANDER DAVIS	18. Mother's Nam	e (First, Middle, Ma SCOTT	iden Sumame)	
	alth and 27 is m			iling Address (Street and Number or Run FENTON PL., LARGO			Code)
nore,	Pages 1 and the property of Hermint: If item		20a. Method of Disposition  20b. Place of Discometery, c.		Date 20	c. Location - City or To	
Baltimore,	permit. P Departme Importan any injury		21. Signatur Service Leonal 19	22. Name and Address of Facility J.	B. JENKIN	CLINTON, MA	
	₫ D E e o		23a. Part1. Energy alsease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	7474 LANDOVER RD.,			Approximate
	Physician /Medical						Interval Between Onset and Death
	Examiner		Due to (or as a consequence of):  Sequentially list conditions  Due to (or as a consequence of):	ARRHYTHMIA OBSTRUCTION			
	euted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events)				
,092	ate be executed hysician and the burial-transit	cal Exa	resulting in death) Last  Due to (or as a consequence of):  d.				
9	tificat ng phy as th						
.O. Box	The law requires that the death certifical to has been signed by the attending phy age 2 should be detached for use as the	Physician/Med		B ☐ Ectopic pregnancy i ☐ Other (specify)		23d. Date of delive Month	ry Day Year
٩.	uires that the de	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to th	e cause of death?
Records,	The law require zate has been si page 2 should t	Completed			24a. Was an autopsy performe	d? prior to condeath?	osy findings available inpletion of cause of
Vital		ø	25. Was case referred to medical	26. Place of Deat	1 Yes 2	No 1 ☐ Yes	2   N0
	ysician: iis certifica director, i	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpat	Cthor		ce 6 ☐ Other (Specify	)
o uo	ding Pt n. After th funeral		27. Manner of Death  1 X Natural 5 Pending (Month, Day Year)  28b. Time (njury)  2 Accident investigation		28d. Describe how	injury occurred	
Division of	I or Attencatter death Director: I in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	Route Number,
	Hospital 4 hours Funeral ely filled	edicai C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the caused at the time, date	se(s) and manner as stop and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	29c. License number		. Date signed (Month, I	
				258182		5-19-0	5
K	(5)		30. Name and address of person who completed cause of death (Item 23a) (Typer C. Down L.) GEORGE 3001	HOSPITAL DRIVE	CHEV	5-19-0. ERLY, MD	20185
	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Typ)  OR O. Do NALD GEORGE 3001 1  31. Date filed (Month, Day, Year)  MAY 2 3 2005	de		/	

		For State Registrar  1. Decedent's Name (First, Middle, Last)	State of Marylan		artment of H rtificate of L		d Mental Hy	Reg. No.		3. Time of	f Ddarb
Physicia /Medic	al	Pao-Chi Lee  4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of De	Month May	1 <sup>Day</sup>	2005	6:20	A M
Examine Funeral Director	er	Casey House 5. Social Security Number 6. Sex		last birthday) Yrs.	Rockv	i11e If Under 24 F		M M	ontgome		or Foreig
	tor	Usual Residence of Decedent           10a. State         10b. County           Maryland         Montgome		ty, Town or Lo						10d. Inside Ci	ity Limits
3a or 28e	Il Directo	10e. Street and Number 17227 Epsilon P	lace		10f. Zip Code	855			zen of What Cou	,	
urs a	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2🌠 No	spanic Origin? n, Mexican, Pu Specify:	' (Specify Yes or No uerto Rican, etc.)		14. Race - Amer Black, White Specify: As		
iene. • than "natur Ire Madical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation a completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of )	working		nd of Business/l	ndustry	
ouid be filed with Mental Hygiene. karked other than latic event, I'le M	To Be C	17. Father's Name (First, Middle, Last)  UNAVAILABL  19a. Informant's Name/Relationship (Ty,			ng Address (Street a	U	Name (First, Middle	ĿΕ			
permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve		Tai Ling Lee Tong  20a. Method of Disposition  1 ⅓ Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)  21. Sign ture 1 Funeral Service License	/ Daughter    20b. F	17227 Place of Dispo cemetery, crea ce of H	Epsilon Sition (Name of matory or other place) Leaven Cen Standard Address E. Deer	Place  Place  metery  as of Facility	Rockvill  May 21, 2005  DeVol Fur	Le, M 20c.Lo Silv neral	aryland cation - City or 1 er Spri Home	20855 Town, State	
Chysician be executed  Madinary Madinar	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, Tany, leading to annual acause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection)  Due to (or as a consection)  Due to (or as a consection)	uence of):	Neoplasm	of Unl	known Pri	mary			
e attending p	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown	d.  3c. If yes, outcome of pregn. 1	al death 3[	Ectopic pregnancy			2	23d. Date of deliv Month	,	Year
iaw requires triat the de as been signed by the a 2 should be detached	by	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the u	nderlying cause give	en in Part I.		_	se contribute to ∑No 3 □ Pro		
rne lav ate has page 2	Completed						_ 24a. Was auto perf 1 □ Yes	psy ormed?	24b. Were aut prior to c death? 1 \( \sum Yes	ompletion of c	availab ause o
aling Priy	tion; To Be	27. Manner of Death 1 X Natural 5 □ Pending	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injun Work	er: 4 🗆 Nursin	Death (Check only only only only only only only only	idence 6		ity) Hospi	ice
or Atten after deat Director: in by the	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Płace of Injury - At h building, etc. (Specia	ome, farm, sti fy)			28f. Location City or To	(Street and wn, State)	d Number or Ru	ral Route Num	iber,
To the Hospital within 24 hours to the Funeral completely filled	edical	(Check only 2 Medical Examination)	sician: To the best of my kno ner: On the basis of examina and manner stated.		vestigation, in my or	oinion, death o		, date and	place, and due	to the cause(s	5)
3	Σ	29b. Signature and title of certifier  30. Name and address of person who of	impleted cause of death (Iter	m 23a) (Type	29c. License	1121	8	29d. Date	e signed (Month	O4	
Sta	te	Charles Harriso  31. Date filed (Month, Day, Year)	n, M.D. 6001	Munca	ster Mill	Road	Rockvill	e, M	aryland	20855	

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death  State of Maryland / Department of Health and Mental Hygiene Reg. No. 05 18842
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last)  MILLER  4b. City. Town, or Location of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death
	Examin Funeral Director	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  4d. County o
	72 hours after death with the Maryland natural; or Items 23a or 28a-f show iteal Eval, it at must be notified at	Funeral Director	10a. State   10b. County   10c. City, Town or Location   10d. Inside City Limits
-0036	hours after dea tural, or Items	þ	11. Marital Status    12. Was Decedent Ever in U.S. Armed Forces?
id 21215-0036	within ane.	Be Completed	Copecify only highest grade completed   College (1-4or 5+)   College (1-4or 5+)     11
Maryland	2 should be and Menta is marked raumatic ev	To B	Edward Crowley  Viola Hodges  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Cryschal Millor (Doughhor 104 Dalacrana Dana 114 Dalacrana Dalacrana Dana 114 Dalacrana Dalacrana Dana 114 Dalacrana Dal
Baltimore, I	e = 5		Crystal Miller/Daughter 104 Delaware Ave, Elkton, MD 21921  20a. Method of Disposition    Date   Dat
Bal	permil. Pa Departmen Important: any injury		21. Signature of Fungral Service Licensee  22. Name and Address of Facility  Andrew G. Gee Funeral Home  23a. Part I. Errer the disease, or complications that caused the death. Do not emersion mode of dynamics of the contract of restriction. MD  21. Signature of Facility  Andrew G. Gee Funeral Home  23a. Part I. Errer the disease, or complications that caused the death. Do not emersion mode of dynamics of the contract of the c
17	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):
8760,	death certificate be executed e attending physician and d for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Our or Character Hamilton Cause (Disease or injury that initiated events resulting in death) Last  c. SPONTANESS BRACKBAR PRESTOULTS  Due to (or as a consequence of):  CAROES - Plumoning APREST  Winnedes
.O. Box 6	that the death certifica ed by the attending ph detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
ecords, P	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
Vital Rec	10	Be Completed	24a. Was an autopsy performed death?  25. Was case referred to medical examiner?  26. Place of Death (Check only one)
Division of V	ding Phy I. After this funeral d	ို	1
Divis	in the	al Certification:	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
	2		30. Name and address, of person who completed cause of death (Item 23a) (Type, Print)  LUIS CAMPOS - PE - LA - BORBOLA BATTHORE, MD 21201
4.	Sta Registi		31. Date filed (Month, Day, Year)  32. Registrar's Signature  MAY 2 4 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State -24-05 PCC Registrar Amend #4b.c. PerPhys. 7thnu 20c. PerFHcr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2100 Nannie McCoy 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Unknown BALTIMORE CTY. Unknown HUS Specialt iversit If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) . last birthday) Birthplace (State or Foreign Country) NORTH CAROL **Funeral** 1 ☐ M 2 1 F 64 Yrs. Unknown Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-1 show the Medical Examiner : wat be notified at 1 ☑ Yes 2 ☐ No Director Unknown Unknown FORT WASHINGTON PG MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? unknown 20744 700 WEST TANTALLON DRIVE USA Unknown 230 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married BLACK 1 ☐ Yes 2 ☒ No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unknown PRIVATE Unknown CHIEF EXECUTIVE 4 YEARS 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental ADDIE GORE is marked Unknown RAYMOND MCCOY unknown ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) unknown 7501 KIPLING PKWY.DIST.HGTS.MD 20747 item 27 i DENEAL/SISTER unknown LENA 20b. Place of Disposition (Name of CEM cemetery, crematory or other place) 20a. Method of Disposition Dc. Location - City or Town, State WASHINGTON, D.C. 5-25-05 Department of Importent: If it eny injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) unknown unknown MOUNT OLIVET! unknown 22. Name and Address of Facility Johnson and Jenkins Funeral Home 21. Signature of Funeral Service Licenses 716 Kennedy St. NW Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PULMONARY EMBELISIY HOUTE Pnysician disease or condition resulting in death) /Medical Examiner RES PIRATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine physician and the burial-transit The law requires that the death certificate be executed MORBID that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. F the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ HYDOVENTILATION SYNDROHE: TRACHEOSTOMY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ELEVATED BICODPRESSURE STATUS POST G.C. BLEED 2 No 1 Yes 2200 Division of Vital Hospitel or Attending Physicien: DIVER TICULOSIS) 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕍 No this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending 2 🗌 No investigation 1 🗌 Yes hours after death unerel Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funerel C

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D000 1346 M44 18 Sames 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUTH CHARLE

State Registrar

DHMH 17 Rev 1/2001

HOSPITAL

ULLIVERSITY SPECIALTY

. Registrar's Signature

LLD

FLYNN

31. Date filed (Month, Day, Year)
MAY 2 4 2005

For	State of Ma					lental H	ygier	ne .		
State Registrar		Ce	ertificate	of Deatl	h		Reg. I	vo.?	105	18814
Decedent's Name (First, Middle, I	ast)					2. Date of I Month		Day	Year	3. Time of Death
Sarah Harre	ll McMilla	n				May	19	d	2005	8:30 H M
4a. Facility Name (If not institution, g	ive street and number)			own, or Location	n of Death	/			nty of Deat	
Doctor's Commu			Lan		.0111			Pri		eorge's
		e (In yrs. last birthda) Q Yrs.	Months	Days Hours		8. Date of 8 (Month, I	Day, Yez		Co	nplace (State or Foreign untry)
141-28-3197 Usual Residence of Decedent	/	9 Yrs.	<u> </u>			June 2	8 19	925	Nort	h Carolina
10a. State 10b. County		10c. City, Town or I	ocation							10d. Inside City Limits
	01-	Unnom	Marlha	ro						1X Yes 2 □ No
MD Prince  10e. Street and Number	George's	Upper	10f. Zip				100.4	Citizen	of What Co	untry?
	Court			774				5 . A .	or writer co	unity :
10815 Kingsmere	12. Was Decedent	Ever in II C 12		· · · ·	Trigin? /Sn	acity Vas or I			Pare - Ame	ncan Indian.
11. Marital Status	Armed Forces?		If Yes, speci	ent of Hispanic C fy Cuban, Mexic	an, Puerto	Rican, etc.)	40-		Black, White	
1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 1 If Yes, Give Year or Dates:	40	1 ☐ Yes 2	No Specif	fy:			Spe	<sup>cify:</sup> B1a	ck
15. Decedent's		16a. Dec	edent's Usual	Occupation			16b.	Kind of	Business/	
(Specify only highest	grade completed)	(Giv	e kind of worl DO NOT use	k done during me	ost of work	ing				,
Elementary/Secondary (0-12)	College (1-4or 5		se Wif	e				Pri	vate	
17. Father's Name (First, Middle, La		1 220			ther's Name	e (First, Midd	lle, Maid			
Walter McMillan				T 11	1a E	larrell	ı			
19a. Informant's Name/Relationship	(Type, Print)	19b. Mai	ling Address	(Street and Num				y or Tox	vn, State, Z	(ip Code)
Diane M. Bayle	es/Daughter	1081	5 Kins	smere C	Court	Upper	MAR	LBOR	RO Maı	yland 2077
20a. Method of Disposition	D) Daugneer	20b. Place of Disp	osition (Nam	e of		Date				Town, State
1 ☐XBurial 2 ☐ Cremation 3  1 ☐ Donation 5 ☐ Other (Spe		Pleasan	ematory or ot t Grov		5/27	/06	St.	Pa	ul,No	rth Carolin
21. Signature of Funeral Service Lic				Address of Fac			-			1 Home
+KD Va-	hall	la l	7474 L	andover						
23a. Part1. Enter the disease, or co	omplications that caused	the death. Do not e						II.C.I	) Land	Approximate
shock, or heart failure. List on Immediate Cause (Fmal										Interval Between Onset and Death
disease or condition resulting in death)	a	ebrovascul	ar Acc	ident					-	
	Due to (or as	a consequence of):								
Sequentially list conditions.	b. — Due to (or as	a consequence of):								
it any, leading to immediate	Due to (or as	a consequence or).								
cause. Enter Underlying	c	a consequence of):								
if any, leading to immediate cause. Enter Underlying Cause (Usease or injuly that initiated events resulting in death) Last	Due to (or as	a odinooquonoo oi).								
that initiated events	Due to (or as									
that initiated events resulting in death) Last	Due to (or as									
that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	d		□Ectoric pre	onancy					Date of deli	,
that initiated events resulting in death) Last	d	2 Fetal death 3	□Ectopic pre				_		Date of deli Month	very Day Year

Pnysician /Medical Examiner

attending physician and for use as the burial-transit is certificate has been signed by director, page 2 should be detach within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir ۴ Certification;

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760.

edlcal E	
ysiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
Completed by Physiclan/Medical	Part II. Other significant condition
o Be Co	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No

27. Manner of Death

1 XNatural

2 Accident

1 - For State Registrar 1. Decedent's N

**Physician** 

/Medical

**Examiner** 

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or Items 23e or 28a-f show any injury or other treumatic event, the Medical Evanties must be redified at aprice. Order.

Completed by Funeral Director

Be မ

24a. Was an autopsy perform

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

1 Yes 21 No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of Injury

29b. Signature and title of certifier

5 Pending investigation

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

D23743

May 19 2005

30. Name and address of person who completed cause of to h (Item 23a) (Type, Print)

Hospital: 1 

Inpatient

28a. Date of Injury (Month, Day Year)

Martin Weltz 7525 Greenway Center Drive Greenbelt, Maryland 20770 M.D.

State Registrar

Medical

31. Date filed (Month, Day, Year) MAY 2 3 2005



State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Bernard Daniel Munson 10:15a <sup>™</sup> /Medical May 15 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 6671 Animal Shelter Rd Hughesville Charles 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□ F 82 Yrs. 218-14-2010 Director 923Accokeek, MD Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "natural", or Items 23e or 28e-f show treumatic event, the Madical Examiner must be notified at 1 ☐Yes 2 ☐ No Director MD Charles Hughesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6671 Animal Shelter Rd 20637 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 □XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: Black 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 7 Hygiene. al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Horticulturist Agriculture 5 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental H Be Henry Munson Harriette Dent 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st.
Department of Health and
Importent: if Item 27 is in
any injury or other treum Helen Belt/Daughter 10401 Cursler Park Drive, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Josephs Cemetery 5/20/2005 Pomfret, MD 21. Signatur # Funeral Service Licansee 22. Name and Address of Facility Joe Baltimore Funeral Home 1622 11th St NW, Wash, 23a. Part 1. Enter the disease or complications that caused the shock, or heart failure. List only one cause on each line. mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death **Physician** Schem'c disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, and landing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consequence of]: Examiner burial-transit that the death certificate be executed attending physician, and for use as the burial-tran Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) the Records, P.O. 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 P No Division of Vital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death Check onli one Other: 4 ☐ Nursing Home 5 ← esidence 6 ☐ Other (Specify) Hospital: 9 12 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After **≥**SNatural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel of within 24 hours at To the Funerel D Medicai 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1200550883 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. NRSup MO 20646 655 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAY 2 3 2005 Registrar

			For State Registrar	State o	f Maryla	nd / Depa	artmen rtificate				lental Hy	giene	105	1 2 3	21.6
			Decedent's Name (First, Middle)	, Last)					Joann	1	2. Date of De		00	3. Time	of Death
	Physici		Beatrice Ma	rv Mal	.issa	MaDay	T				Month	Day	Year <b>2005</b>		45 A <sup>M</sup>
	/Medio Examin		4a. Facility Name (If not institution			McDar	T	Town, or	Location of	of Death	May		ounty of Death		43 A
	LXamii		Salisbury Nursi		,	nter	,				, Md.		comico		
	Funeral		5. Social Security Number	6. Sex		s. last birthday)		1 Year	If Under	24 Hrs.	8. Date of Bir (Month, Da			place (Sta	te or Foreign
	Director		213-10-3431	1 □ M 2 🛣 F	97	Yrs.	Months	Days	Hours	Min.	(Month, Da 2/23/1	ay, Year)		,,	
	υ		Usual Residence of Decedent								2/23/1	300	Peni	ısylv	anıa
	nylan how		10a. State 10b. County		10c. C	City, Town or Lo	ocation							10d. Inside	City Limits
	e Ma	ç	Maryland Wico	mico		Salish	oury							1 🔀 Y	es 2 No
	th th or 28	Director	10e. Street and Number				10f. Zip	Code				10g. Citizer	n of What Cou	ntry?	
	23a	ai	200 Civic Ave				21	804				USA			
	r dea	Funerai	11. Marital Status	12. Was Dece Armed Fo	edent Ever in	U.S. 13.	Was Deced	ent of His	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)	- 14.	Race - Ameri Black, White,		1
36	or it	핏	1 Never Married 2 Marri	ied 1 □ Yes If Yes, Giv	2 <b>X</b> No ve		1 ☐ Yes 2		Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			pecify:		
Ö	ural',	d by	3  Widowed 4 □ Divorced	Year or D	ates:								, oc., y.	WN:	ite
21215-0036	be filed within 72 hours after death with the Maryland tal Hygjene. d other then "neturel", or Items 23a or 28e-1 show event, the Medical Evanteer must be notified at	Completed	15. Decedent (Specify only highes	's Education t grade completed)		(Give	dent's Usua kind of wor	k done d	lurina most	t of workii	ng	16b. Kind	of Business/Ir	ndustry	
12	withir ane. than	E D	Elementary/Secondary (0-12)	College (	1-4or 5+)		DO NOT us	· ·	,			Manh	atton 6	'hizt	Factor
-	filed with Hygiene thar tha		17. Father's Name (First, Middle, I	(ast)		OIII	ce Cl	,	18 Mothe	r'e Namo	(First, Middle			HILL	ractor
an an	Mental Mental arked o	) Be	Charles Boston	,							Rachel	,	,		
MCDANIEL, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Evantual must be notified an once.	2	19a. Informant's Name/Relationsh			19b. Mailii	na Address	(Street a			Racile1			Code)	
Ma Ma	and 2 sauth ar n 27 is iar trau		Donald McDanie								n, MD		om, otato, za	00007	
(D)	tam 27		20a. Method of Disposition	z, nepnew	20b.	Place of Dispo	osition (Nam	e of	ne, r		ate		ion - City or To	own, State	
ICI O	Pages nent of I int: If its iry or o		1 XBurial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (St		State	Wicomic				5/20,	/05	Salid	bury, M	/ID	
SATRICE N	permit. Pages Department of Important: If it any injury or c		21. Signature of Funeral Service			. 20	2. Name and				703	Salls.	bury, r	לעני	
BEATRICE Baltimore	permit. Departn Importa any inju	4	- · / a	1		1-24 H	ollow	av F	unera	il Ho	me Pro	fessio	nal As	socia	ition
			23a. Part1. Enter the disease, or	complications that of	aused the dea	ath. Do not ent	er the mode	OW H	JIII K	cardiac o	Salisbi r respiratory a	ury, M	ID 2180	4 Approxin	nate
	Dharistan		shock, or heart failure. List of Immediate Cause (Final	only one cause on e	each line.	,	2	Λ						Interval E Onset ar	Between nd Death
	Physician /Medical		disease or condition resulting in death)	a. Duo to	(or as a conse		9-7	Ne	200 Dega					1ean	7
	Examiner			(2	(O) as a conse	iquence or).	6		0.	<i>.</i>					
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	or as a conse	quence of):			الم الم	2	26		2	200	<del></del>
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		/		/								
o,	exec an an rial-tr	Exa	resulting in death) Last	Due to (	(or as a conse	quence of):							-		
8760,	cate be executed bhysician and the burial-transit	dicai		d											
9	tifica ng ph as th	ledi													
ŏ	eath certific attanding p	In/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregr		Ectopic pre	anana.				23d	. Date ol deliv	ery	
œ.	deat e att	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregn	ant at time of		Other (spe						Month	Day	Year
o.	by the a	Physician/Me	9 Unknown	9□ Unkno											
Division of Vital Records, P.O. Box	w requires that been signed b should be deta	by	Part II. Other significant conditio	ns contributing to de	eath but not re	sulting in the u	nderlying ca	use give	n in Part I.		23e. Did t	obacco use	contribute to the	he cause o	of death?
ord	en si										10	Yes 2 ☑⊀	lo 3□Prob	bably 4	Unknown
သို့	law reas be	Completed									24a. Was	an 2	4b. Were auto	psy finding	s available
Ě	rsician: The law s certificate has b lirector, page 2 s	mo.									perfo	osy rmed?	death?		cause of
ita	ian: rtiffice stor, p	BeC	25. Was case relerred to medical						26. Place	of Death	(Check only o				
<b>-</b>	nysic lis ce direc	2	examiner? 1 Yes 2 No	Hospital: 1 □ I	npatient 2	☐ ER/Outpatien	nt 3 DO	A Other	r: 4 🗐 Nui	rsing Hom	ne 5 ☐ Resid	dence 6	Other (Specif	y)	
0 [	ng Pł		27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of	of Injury th, Day Year)	28b. Time of Injury	28	Bc. Injury Work			8d. Describe I				
0.0	andi eath. or: A he fu	ati	2 ☐ Accident investig	ation			М		es 2□N	No					
Ξ	r Att	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned   208. Place	of Injury - At I	nome, larm, str ify)	eet, lactory,	office		2	8f. Location (5 City or Tox	Street and N vn, State)	umber or Rura	I Route N	umber,
	ital curs af	ပီ													
	Hosp 4 hou Funa ely fi	edical	Check only 2 Medical E	g Physician: To the Examiner: On the ba	asis of examin	owledge, death ation and/or inv	occurred a vestigation.	t the time	e, date and inion, deat	d place, a h occurre	nd due to the	cause(s) and	d manner as s	tated.	a(s)
	To the Hospital or Attanding Physician: The law requires that the death certific within 24 hours after death.  To tha Funaral Diractor: After this certificate has been signed by the attanding pompletely filled in by the funeral director, page 2 should be detached for use as	Med	one) 29b. Signature and title of certifier	and manr	ner stated.			License							
	F 3 + 8	-	235. Signature and title or certifier	1						0		Zau. Date Si	gned (Month,	uay, rear	,
	S	-	1000	Thus				12	23	7		3/1/	18/5		
	12		30. Name and address of person william ROBINS,					थाप्र	, MD	210	04	/			
	Sta	te.	31. Date liled (Month, Day, Year)	32 Pa	mistrar's Sign	ature			, 110 •	£.(U	<del></del>				
E	Registr		MAY 2	2005	her	J. A	melle	,							

			Ficase		partment of Health and M	•	_	
			1 - For State Registrar	· ·	Certificate of Death	Reg. Ne	2005	18847
	Physicia	20	1. Decedent's Name (First, Middle, Last			2. Date of Death Month Da		3. Time of Death
	Physici /Medio	al		Murphy		5/1	7 2005	2100 PM
1	Examin	er	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death	· 40	County of Death	•
	Funeral		5. Social Security Number Se		(ay) If Under 1 Year If Under 24 Hrs.	9. Date of Birth	9. Birthpla	ace (State or Foreign
н	Director		579-36-9520 <sup>12</sup>	M 2□F 75 Yrs	Months Days Hours Min.	FEB. 23, 1	930 WASHIN	GTON, D.C.
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town o	r Location		100	d. Inside City Limits
	Maryli f sho	ŏ	MARYLAND WORCEST					1 X Yes 2 □ No
	n the	Director	10e. Street and Number	DK OODIN	10f. Zip Code	10g. C	itizen of What Countr	γ?
	23a c	ra D	13324 ATLANTIC		21842		USA	_
	er des Items	nue	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No	<ol> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> </ol>	ecify Yes or No- Rican, etc.)	<ol> <li>Race - American Black, White, et</li> </ol>	
336	urs aft	by F	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: KOREAN	1 ☐ Yes 2 X No Specify:		Specify: WH]	ITE
21215-0036	be filed within 72 hours after death with the Maryland nat Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be notified at	Completed by Funeral	15. Decedent's Edu (Specify only highest grad	(Cation   16a. D	ecedent's Usual Occupation Give kind of work done during most of work	ing 16b. I	Kind of Business/Indu	ıstry
121	within iene. than	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	fe. DO NOT use retired) FIREFIGHTER		ICIPAL GOV	(/FDNMFNT
N	Hygi ther int,		12 17. Father's Name (First, Middle, Last)			e (First, Middle, Maide		VERNPIEN I
lan	should be nd Mental marked o	To Be	FRANK	MURPHY	GRACE	СГОН	ERTY	
Maryland	2 should and Men Is marke aumatic	[	19a. Informant's Name/Relationship (T)		lailing Address (Street and Number or Rur			
	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		RUTH J. MURPHY/W		24 ATLANTIC BLVD., isposition (Name of		, MD 21842 ocation - City or Tow	
nor	Pages 1 nent of h int: If ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ f	Removal from State cemetery,	crematory or other place)		ELMAR, DEL	
Baltimore,			<ul> <li>4 □ Donation 5 □ Other (Specify,</li> <li>21. Signature of Funeral Service Licens</li> </ul>		22. Name and Address of Facility	1/05	ELFLAR, DEL	IAWAKE
m	permit. Departr Importa any inji		rales (	Hart	HASTINGS FUNERAL H	OME, SELBY	VILLE, DE	. 19975
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. Due to (or as a consequence of)  Due to (or as a consequence of)			1	Approximate Interval Between Onset and Death
8760,	eath certificate be executed attending physician and for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated svents resulting in death) Last	c				-Australia - Australia
.O. Box 68	0 0	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death  4 Pregnant at time of death  9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month D	y Day Year
rds, P	sigr d be	þ	Part II. Other significant conditions co	ntributing to death but not resulting in th	ne underlying cause given in Part I.		use contribute to the	e cause of death? bly 4 Unknown
Il Records,	The law ate has b page 2 si	Completed				24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ N	prior to comp death?	sy findings available pletion of cause of
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	Other	h (Check only one)	·	
of	Phys r this aral di	. To	1 ☐ Yes 2 No 27. Manner of eath	28a. ate of Injury 28b. Tim	ne of 28c. Injury at	ome 5 Residence 28d. Describe how inju		
ion	Attending r death. sctor: Alter oy the fune	ation	TANatural 5 Pending investigation	(Month, Day Year) Inju	M 1 □ Yes 2 □ No			
Division	E 0 F 0	Ce tification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street a City or Town, Star	nd Number or Rural i re)	Route Number,
	ne Hospital n 24 hours ne Funeral I	edical	29a. Certifier (Check only one) Certifying Physical Example 1997 (Check only one)	valcian: To the best of my knowledge, ciner: On the basis of examination and/or and manner stated	leath occurred at the time, date and place, or investigation, in my opinion, death occur	and due to the cause(s red at the time, date ar	s) and manner as stated and place, and due to t	ted. the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certaier	////	29c. License number		ate signed (Month, D.	
	nel		CHI !	ell, m	) NOGO	/\	5-18-0	05
	IVA		30. Name and address of person who c		OSFILE POBOX 17	37 51	5-18-	12180-
: €.	Sta		31. Date filed (Month, Pay, Year)	2 Agistrar's Signature	South !	i//	Y	
	Registr	rar	111111 202	MERCURY JU'	REPORT			1

1				1 = For State Registrer	State of Marylar		rtment of		d Mental Hy	giene	005	18848
Anna Elizabeth Marano  Family Mary 107, 2005 5;30 P M  Accept Acceptance of Control of C		D		1. Decedent's Name (First, Middle, Last)							Voor	3. Time of Death
## Country of Dash  ## Cou				Anna Elizab	eth Ma	rano						5:30 P M
Source   S				4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,	, or Location of D	eath	4c. C	ounty of Death	
Description of the property of				2023 Franwall Ave	nue				_			
Ogd-10-5546   Summer of December   10c. County   10c. Co. There is no cludation   10c. County   10c.		Funeral			144 2X7 E				Min. (Month, D.	th ay, Year)	9. Birth	
The state of the		Director		098-10-5546	9	3 Yrs.			April	20, 19	912 Per	nnsylvania
The following part of the part		and w	1		10c. Ci	ty, Town or Lo	cation				1.	Od. Inside City Limits
The following part of the part		Aaryl Fsho	5	Marriand Montgome		Whostor						1 ☐ Yes 2X No
The following part of the part		28a-	ect		Ly	Wileacoi				10a. Citize	on of What Cou	ntrv?
The following part of the part		with se or	ā		venue							,
The following part of the part		ns 20	era		12. Was Decedent Ever in U	J.S. 13. V	Vas Decedent of	f Hispanic Origin	? (Specify Yes or No	o- 14	. Race - Americ	
The following part of the part	0	r Iter	Fur	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 🔀 No				uerto Rican, etc.)			
The following part of the part	8	el', o	by	3 👿 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		⊔Yes 2LLIN	o <i>Specity</i> :		Si	pecifyWn1t(	2
The following part of the part	20	72 ho	eted			16a. Deced	lent's Usual Occ	upation ne during most of	workina	16b. Kind	of Business/In	dustry
The following part of the part	2	ithin le.	n ple			life. L	OO NOT use reti	red)				
Mena Marano / Daughter 2023 Frankall Avenue, Wheaton, MD 20902  20a. Method of Discostion  1	7	ed wygien ygien yer th	Co			Hon	nemaker	1				Home
Mena Marano / Daughter 2023 Frankall Avenue, Wheaton, MD 20902  20a. Method of Discostion  1	ū	be fill H doth	Be								umame)	
Mena Marano / Daughter 2023 Frankall Avenue, Wheaton, MD 20902  20a. Method of Discostion  1	<u>X</u>	Men Men Marke Metic	2			401 14 11						0.10
203. Mehood of Disposition and State   200. Execution City of Town, State   200. Execution City of Town, State   200. Metropolitan Crematory   2005   Alexandria, Virginia   2005   Alexandria   2005   Alexan	Nar	12 sh and rism reum										Code)
Providician (Approximate Interval desease, or composition and clause (Final desease) or control above on each line. List of the clause (Final desease) or control above on each line. The control of the clause (Final desease) or control above on each line. The control of the clause (Final desease) or control of the clause of desease) or control of the clause		1 and 1ealth 1m 27 ther t										own State
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Providician (Approximate Interval desease, or composition and clause (Final desease) or control above on each line. List of the clause (Final desease) or control above on each line. The control of the clause (Final desease) or control above on each line. The control of the clause (Final desease) or control of the clause of desease) or control of the clause	ΕĦ	then tent:		^ -								rginia
Provided Staminer    Medical Examiner   Medical Exa	Bal	Depar Impo eny ir		21. Signature if Fineral Service License	Cole							, MD 20901
Prival Cate				23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the dea e cause on each line.	th. Do not ente	er the mode of d	ying, such as car	diac or respiratory a	arrest,		Interval Between
Due to (or as a consequence of):  Atrial Fibrillation  Due to (or as a consequence of):  Classe (Disease or infus):  The standard overties that indicated events the standard events that indicated events that indicated events the standard events that indicated events that indicated events the standard events that indicated events that indicated events the standard events that indicated events that indicated events the standard events that indicated events that indicated events the standard events that indicated events that indicated events the standard events that indicated events that indicated events the standard events that indicated events that indi	1	Pnysician		disease or condition	Congestive	Heart F	ailure					Onset and Death
Securify Sec	H			resulting in death)	Due to (or as a consec	quence of):						
The far instance of the control of t		Lxammer	_	Sequentially list conditions, b	)		n					
The far instance of the control of t		ed isit	ine	Cause (Disease or injury	Due to (or as a consec	querice or).						
Second   Color   Col		and al-trar	хап	that initiated events C.		quence of):						
The property of the property o	9	be e sician buris										
Tron Deficiency Anemia, Hypothyroidism, Depression,    Sacral Ulcer Stage IV   24a. Was an autopsy findings available profit to completion of cause of death?   1   1   1   1   1   1   1   1   1	$\infty$	ficate physis the	edlo	0								
Tron Deficiency Anemia, Hypothyroidism, Depression,    Sacral Ulcer Stage IV   24a. Was an autopsy findings available profit to completion of cause of death?   1   1   1   1   1   1   1   1   1		certi nding use a	N/W							23	d. Date of delive	ery
Tron Deficiency Anemia, Hypothyroidism, Depression,    Sacral Ulcer Stage IV   24a. Was an autopsy findings available profit to completion of cause of death?   1   1   1   1   1   1   1   1   1	ă	death a atte	iclai	in the past 12 months?	4 Pregnant at time of o						Month	Day Year
Tron Deficiency Anemia, Hypothyroidism, Depression,   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 1   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 1   Yes 2	0	the cy by the ached	hys		9□ Unknown							
25. Was case referred to medical seaminer?  1		s thai ned b		Part II. Other significant conditions con	tributing to death but not re-	sulting in the ur	nderlying cause	given in Part I.	23e. Did	tobacco use	e contribute to t	he cause of death?
25. Was case referred to medical seaminer?  1	<u>5</u>	quire n sig uld b	d be	Iron Deficiency A	nemia, Hypot	hyroidi	sm, Dep	ression,	1	Yes 2X⊡	No 3□ Prot	pably 4 Unknown
25. Was case referred to medical seaminer?  1	CO	s bee	olete	Sacral Ulcer Stag	re TV						24b. Were auto	psy findings available
25. Was case referred to medical seaminer?  1	Re	The la	mo	343242 3232 3343					perf	ormed?	death?	
27. Manner of Death 1	ta		0	25. Was case referred to medical				26. Place of			1 1 100	20110
27. Manner of Death 1	<u>=</u>	ysici is cer direc			iospital: 1 Inpatient 2[	ER/Outpatien	t 3 DOA	)then			☐Other (Special	ý)
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  D34472  May 18, 2005  30. Name and address of terson who completed cause of death (flem 23a) (Type, Print)  Lynne Diggs, M.D. 10400 Connecticut Avenue, #206, Kensington, MD 20895	0	g Ph er thi			28a. Date of Injury		28c. In					
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  D34472  May 18, 2005  30. Name and address of terson who completed cause of death (flem 23a) (Type, Print)  Lynne Diggs, M.D. 10400 Connecticut Avenue, #206, Kensington, MD 20895	0	ath. r: Aff	atlo	2 Accident investigation	(Morall, Day 1 day	inquiy						
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  D34472  May 18, 2005  30. Name and address of terson who completed cause of death (flem 23a) (Type, Print)  Lynne Diggs, M.D. 10400 Connecticut Avenue, #206, Kensington, MD 20895	<u>Vis</u>		tific	determined			et, factory, offic	е			Number or Rura	al Route Number,
30. Name and address of Gerson w(o completed ause of death (flem 23a) (Type, Print)  Lynne Diggs, M.D. 10400 Connecticut Avenue, #206, Kensington, MD 20895		tel ol rs aft el Di ed in	Cer								<u>.</u>	
30. Name and address of Gerson w(o completed ause of death (flem 23a) (Type, Print)  Lynne Diggs, M.D. 10400 Connecticut Avenue, #206, Kensington, MD 20895		e Hospi 124 hour e Funer letely fill	dical	(Check only 2 Medical Examin	ner: On the basis of examina	owledge, death ation and/or inv	occurred at the estigation, in my	time, date and p y opinion, death o	lace, and due to the occurred at the time	cause(s) ar date and p	nd manner as s lace, and due t	tated. the cause(s)
30. Name and address of Gerson w(o completed ause of death (flem 23a) (Type, Print)  Lynne Diggs, M.D. 10400 Connecticut Avenue, #206, Kensington, MD 20895		To th withir To th comp	Me	29b. Signature and title of certifier	2					29d. Date	signed (Month,	Day, Year)
Lynne Diggs, M.D. 10400 Connecticut Avenue, #206, Kensington, MD 20895	}				~			D344/2		May	18,	2005
Lynne Diggs, M.D. 10400 Connecticut Avenue, #206, Kensington, MD 20895  State Registrar  MAY 1 9 2005  State				30. Name and address of person who co	mpleted sause of death (ite	m 23a) (Type,	Print)			-		
State 31. Date filed (Month, Day, Year)  Registrar  MAY 1 9 2005	_			Lynne Diggs, M.D.	10400 Conn	ecticut	Avenue	, #206,	Kensingto	on, MD	20895	
	**				3 Registrar's Sign	ature (00	all!					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** Antonia Meravoglou 17, 2005 5:30 P May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2 □XF 214-74-8868 Director 78 1926 Greece Sept. 16, Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County in than "naturel", or Items 23a or 28a-f show the Medical Exercitor must be notified at 1 ☐ Yes 2 XNo Director Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1022 Devere Drive 20903 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Bace · American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturel", or Iten any Injury or other traumatic event, If a Medical Exercitiva once. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes Ž☐ No Specify: Specify: White 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maria Parginos Demitrios Evagelatos 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Miranda M. Rangoussis/Daughter 1022 Devere Drive, Silver Spring, Maryland 20903 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) May 20, 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery Silver Spring, Maryland \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. Willia 500 University Blvd, W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonia Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury Due to (or as a consequence of): Examine sician and burial-transit The law requires that the death certificate be executed Shock that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical Cerebrovascular Accident use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the Š signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖺 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes certificate **X**□ No 1 ☐ Yes Division of Vital Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1₺Inpatient 2☐ER/Outpatient 3☐DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 🎛 No his 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined within 24 hours after der To the Funeral Directo completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29d. Date signed (Month, Day, Year) 2 A.Nawaz D50987. 20 Name and address of person who completed cause of death (Item 23a) (Type, Print)

HMED NAWA2 PO BOX 83819 GAITHERSBURG MD 20883 AHMED NAWAZ

State Registrar 31. Date filed (Month, Day, Year)

MAY 2 0 2005

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Mille-**Physician** Jeanne 1840 М May 30 2005 /Medical 4c. County of Death Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Internet Cry JOHNS Sotrah 8. Date of Birth (Month, Day, Year) March 5, 1941 8. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Hours Days Months 1 □ M 2 X F 460-23-7784 Minnesota 64 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show Exac ther must be notified at 1 ☐ Yes 2 🕅 No PA York New Freedom Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 17349 131 South Front Street U.S.A. Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 X Married ☐ Yes 2 No Yes, Give White Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 'naturel' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Electronics and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Manufacture Machine Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lawrence W. Richard Delores N. Leonard ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) George E. Miller, Sr./Husbard 131 South Front St., New Freedom, PA 17349 t of Health other t 20b. Place of Disposition (Name of Cemetary, crematory or other place of Preedom Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition ther place) June 4, 1 XBurial 2 ☐ Cremation 3 X Removal from State ō rtment New Freedom, PA 4 □ Donation 5 □ Other (Specify) 2005 injury perrit.
Dep rtm
Impc rte
any inju Deserture of Euneral Service Licensee 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. far Costa 24 Second St., New Freedom, PA 17349 awes: 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician interstial disease lung two months /Medical Due to (or as a consequence of): **Examiner** tarcern chemotherapy Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transil acleno careino 1400 Due to (or as a consequence of): Box 68760. attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ίς Dav Year in the past 12 months? 1 ☐ Yes 2 🛣 No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 No 1⊠Yes 2□ No 1 Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1. ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 **>**No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a l i led 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 30, 2005 Brian Garbalde RES-000 600 North Wolfe Street 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimere Mayland 21287 Johns Hophens Horge Brian Car, baloh Tower 110 Doctor's Louise

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State

Registrar

DHMH 17 Rev 1/2001

JUN 0 6 2005

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			1- State of Maryland / Dep	artment of Health and Nertificate of Death		eņe g. No. 005	8851
			Decedent's Name (First, Middle, Last)		2. Date of Death	1	3. Time of Death
	Physicia		Edward Walter Naquin, Jr.		May 18,	2005	12:40P M
F	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1221101
			10630 Ashford Circle	Waldorf		Charles	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth (Month, Day,	9. Birtho	place (State or Foreign
	Director		5//-46-//05	Million Days	Aug. 20	, 1934 Loui	siana
	pur *	}	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	ocation	· · · · · · · · · · · · · · · · · · ·		IOd. Inside City Limits
	l sho	5					1 ☐ Yes 2 X No
	28e-1	ect	Maryland Charles Waldors	10f, Zip Code	10	og. Citizen of What Cour	ntry?
	with la or	Funeral Directo	10630 Ashford Circle	20603			,
	ns 23	era		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		United Stat	
0	r iter	F	Armed Forces?  1 □ Never Married 2 □ Married   1 M Yes 2 □ No   1 Yes, Give		Rican, etc.)	Black, White,	etc.
<u> </u>	af', o	þ	3 M Widowed 4 □ Divorced	1 ☐ Yes 2 No Specify:		Specify: Whi	te
ဂ္ဂ	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural", or items 23s or 28s-f show event, the Medical Examinar must be inclified at	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	CIDO	6b. Kind of Business/In	dustry
7	ithin ne.	du	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		Mashington	DC
2	ted w lygier her th	S		nager		Government	
Maryland 21215-0036		Be	17. Father's Name (First, Middle, Last)		e (First, Middle, M		
چ	should be fited withir ind Mental Hygiene. s marked other than umatic event, Ite M	ို	Edward W. Naquin, Sr.  19a. Informant's Name/Relationship (Type, Print)  19b. Mai	ing Address (Street and Number or Rui	Ann Knigh		Code
<u>s</u>	d 2 sho			Belfast Rd., Waldo			Code
	is 1 and 2 should of Health and Mer itam 27 is marke other traumatic					Oc. Location - City or To	own, State
٥	Pages nent of int: If it iny or o		I Laburar 2   Cremation 3 Linemovarion 3tate 1	4			
Baltimore,	artme ortan injur	- 4	21 Signature of Fulleral Service Licensee /	tion Cemetery 05-2 22. Name and Address of Facility			87-1
E E	permit. Pages 1 Department of H Important: If Ital eny injury or ott		M00053	Huntt Funeral Hom P.O. Box 156, Wal	e MD	20604 0156	
A.			23a. Patt1. Enter the disease, or complications that caused the death. Do not en	ter the mode of dying, such as ardias	or respiratory arre	20604-0156 st,	Approximate
	Physician	1	sheck, or heart failure. List only one cause on each lin Immediate Cause (Final	to Mallit	1		Interval Between Onset and Death
100	/Medical		disease or condition resulting in death)  Due to (or as a consequence of):	are practice	0		10 MV
	Examiner						,
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	cuted	Examiner	that initiated events c.				
Ö,	e exe ian a urial-1	Ex	resulting in death) Last Due to (or as a consequence of):				
8760	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai	d				
Ó	entific ling p	Mec	IF FEMALE:				
ROX	leath certific attending p	Physician/Me		□Ectopic pregnancy		23d. Date of delive Month	ery Day Year
o	at the de by the a stached f	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 9 ☐ Unknown	Other (specify)			
7.	that the ed by detac	Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the	ne cause of death?
<b>Records</b> ,	uires that signed b	d by			1 ☐ Yes	s 2 No 3 Prot	pably 4 Dunknown
Ö	w requ been shouk	Completed			24a. Was an	24h Were auto	psy findings available
Ĕ	The lav	du			autopsy perform	ed? prior to co	mpletion of cause of
Vital	<i>ra</i> ==	e Co	25. Was case referred to medical	OS Plans of Davi		☐ 1 ☐ Yes	2 No
		0 8	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie	Other	th (Check only one	nce 6 ⊡Other (Specif	iv)
ō	g Phys er this eral di	$\vdash$	27. Manger of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how		77
0	Attending I death. ctor: After y the funer	atio	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division	er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
ā	tel or rs afte al Dir ed in	Cer	The second secon				
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	29a Certifier (Check only (Che	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the car	use(s) and manner as site and place, and due to	tated. the cause(s)
	To the Hos within 24 h To the Fur completely	Medi	one) and/manner stated				· · · · · · · · · · · · · · · · · · ·
	with To Con	<	29b. Signature and title of certifier	29c. License number	< 29	d. Date signed (Month,	
			- Summe	UUUII	)	5-12-0	>
P	BIM.		30. Name and address of person who completed cause of death (Item 23a) (Type	ke Sq. #104, Waldo	rf MD 20	0603-4804	
*	Sta	10	Daniel M. Howell, MD, 11345 Pembroo		119 110 20	3003 4004	
100	Registr		31. Date filed (Month, Day Year) MAY 2 3 2005	Apole			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May **Physician** Margaret N. Paulson 2005 22, 12:38A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Laurel Regional Hospital Laurel Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day. **Funeral** 1 □ M 2√2 F 81 Yrs. 335-18-6490 Director Nov.6,1923 Wisconsin Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic avant, the Medical Examiner must be notified at Maryland Prince George's Silver Spring 1 ☐ Yes 🏖 ☐ No Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ŏ 3148 Gracefield Road, CL109 20904 United States Itams 23a 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🖾 No Specify: White Specify Be Completed by 3 XWidowed 4 □ Divorced 'natural' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) 1-4 Elementary/Secondary (0-12) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) s and Mental I 1 and 2 should be Albin Α. Appelquist Nan Lundquist 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 902 Falls Bridge Lane Great Falls, Va. 22066 Richard S. Paulson -son nt of Health a t: If itam 27 Is r or othar tra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any njury or once. Metropolitan Crematory 5/22/2005 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, PA 21. Signature of Funeral Service Licensee 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician days Respiratory Failure /Medical Due to (or as a consequence of): **Examiner** Chronic Obstructive Lung Disease **YOURS** Sequentially list conditions, if any, backing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consequence of] Physician/Medical Examiner the burial-transit or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ğ in the past 12 months? 1 ☐ Yes 2 🔀 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. detached the 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, should be Urinary Tract Infection 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 ☐ Yes 2 XNo 1 Yes 2 🗆 No funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 XInpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division After 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide filled X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated within 2 To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D34590 May 22,2005 rel 30 Roy Fried, MD 3110 Gracefield Road Silver Spring, Maryland 20904 31. Date filed (Month, Day, Year) Registrar's Signature State MAY 2 4 2005 Registrar

		•	For State Registrar  1. Decedent's Name (First, Mic	idle ( ast)	State of	Marylar		artmen rtificate				lental l	Reg. No.	005	853	_
	Physicia			310, Last)				_				Month	Day			
	/Medic	al	Barbara		Salt		Pe	ckern			D	May			9:30 a	
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			Washington Ad			-	14 5 -45 -11	Tak If Under		Park If Under		O Data a		Montgo		
	Funeral Director		5. Social Security Number 177 24 2675	6. Sex 1 □	M 2 <b>X</b> F	7. Age (In yrs. 73	Yrs.	Months		Hours	Min.		f Birth b, Day, Year) <b>26,</b> 1		irthplace (State or Foreign Country) nnsylvania	
	<b>y y</b>	}	Usual Residence of Decedent  10a. State 10b. Cour	itv		10c Ci	ty, Town or Lo	ocation							10d. Inside City Limits	-
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	ar de	une	11. Marital Status		Armed For	ces?	7.5.	If Yes, spec	offy Cuba	an, Mexica	n, Puerto	Rican, etc.	.)	Black, Wh		
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2	withii ane. than	m	Elementary/Secondary (0-12	)	College (1-	-4or 5+)				•			77.7			
2	thar nt.		17. Father's Name (First, Midd	e Last)	4			Lea	cher		er's Nam	e (First, Mi	ddle, Maiden		y School	_
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene it the state of 23 are 1884 then with the "natural", or Itams 23a or 28a-1 show item 27 is marked other than "natural", or Itams 23a or 28a-1 show other traumatic event. The Martical Examination use the multiple at	Be	Donald Mille							E A	_11_	C-1.				
Ë	Jould James Mark Mark	10	19a. Informant's Name/Relation		na Print)		10b Maili	na Addrace	(Street			Sal1		r Town, State,	Zin Codel	-
ā	12 st h and ris n		David M. Peck					•					_			
0	tealtl m 27			Стща	u / 501							Oate			.C. 20015 or Town, State	-
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or ott		20a. Method of Disposition  1 Burial 2 Cremation	n 3 □R	emoval from S	State	Place of Dispo cemetery, crea	matory or o	ther plac	ce)		Julio	200. 20	Cation - City C	i rown, state	
<u>E</u>	Pag men ant: ury		`4 ☐ Donation 5 ☐ Other	1		○ Ft	Linco	ln_Cr	emat	ory	5/2	/200	Brei	twood,	, Maryland	_
att	ppart poort ny in		21. Signature of Funeral Servi	Licerse	90 /	la de la constantina della con	2:	2. Name ar	nd Addre	ss of Facil	<sup>ity</sup> Hine	es Rin	naldi 1	[unera]	l Home	
0	90 E 29	1	Burne	-4	din	Du-	1	1800	New	Hamp:	shire	e Ave	Silve	r Spri	ng, MD 20904	
			23a. Part1. Enter the disease, shock, or heart failure. L	or compli	cations that ca	aused the dea	th. Do not en	ter the mod	le of dyin	ng, such as	s cardiac	or respirato	ory arrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final		(0)	ptic	Sh	ads	7						Onset and Death	
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п	Examiner				Le	000	DAR	0								
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	uted 3 ansit	교	Cause (Disease or injury that initiated events	1	U	een	al	es I	69	C		note	di	C/h		
ď.	ate be executed hysician and the burial-transit	Examine	resulting in death) Last		Due to (	or as a consec	quence of):	9				9				
160	ysicia ysicia	cal		•												
68	ficate phy is the	edic														
×	death certifica e attending ph d for use as tl	M	IF FEMALE: 23b. Was decedent pregnant	2	3c. If yes, outo	come of pregn	ancy							23d. Date of d	Jelivery	
Вох	atter for u	Physician/M	in the past 12 months?			irth 2 Feta ant at time of		∃Ectopic pi ∃ Other <i>(sp</i>		У				Month	Day Year	
o.		ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		9☐ Unkno				,							
<u>α</u>	that the de ed by the detached		Part II. Other significant cond	itions cor	ntributing to de	eath but not re	sulting in the u	anderlying o	ause giv	en in Part	1.	23e.	Did tobacco u	se contribute	to the cause of death?	
Š		l by	•		•				•				Yes 2	]No 3□	Probably 4 Dunknown	
ecord	law raquires as been sign 2 should be	ompleted												- 120		
ec	e law has b	nple											Was an autopsy	prior to	autopsy findings available of completion of cause of	
<u>m</u>	Th ate	Con										1 🗆 Y	performed? es 2 No	death?		
Vital	Physician: This certifical	Be (	25. Was case referred to med examiner?	cal						26. Plac	e of Deat	h (Check c	nnly one)			
<u>_</u>	Physic this ce al dire	2	1 ☐ Yes 2 No	Н	lospital:	npatient 2	ER/Outpatie	nt 3 🗆 D0	Oth Oth	ner: 4□N	lursing Ho	me 5 🗆	Residence	6 □Other (Sp	oecify)	
n of		ü	27. Manner of Death 1 Natural 5 □ Per	dina	28a. Date of	of Injury h, Day Year)	28b. Time of Injury	of 2	28c. Injur Wor	ry at rk?		28d. Desc	ribe how injur	y occurred		
<u>.</u>	Attending r death. actor: After by the fune	atlo	2 Accident inve	stigation				М	1 🗆	Yes 2	]No					
Division	Atte	Certification		ld not be emined	28e. Place	of Injury - At h	nome, farm, st	reet, factor	y, office				ion (Street an r Town, State		Rural Route Number,	
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	To the Hospital or Attend within 24 hours after death To the Funaral Director: completely filled in by the				sician: To the											
	tha Ho nin 24 the Fu	edical	one)	ai Examii	and manr		ation and/or in	ivestigation	i, in my c	pinion, de	atri occur	red at the t	ine, date and	piace, and d	lue to the cause(s)	
	within To the To the To the Comp	Ž	29b. Signature and title of cert	ifier		00	W	29	c. Licens	se number	-100	•	29d. Da	e sighed (Mo	nth, (Day, Year)	
	.11		> Xel	2 (	Ill	2		_	1)0	45	4	10	S	115	105	
	10		30. Name and address of pers	on who co	ompleted caus	e of death (Ite	m 23a) (Type	, Print)						1		_
									i ii	Wash	inct	on D	C 20	010		
	Sta	ite	Yudh V. Gup1 31. Date filed (Month, Day, Ye MAY 2	ar)	32/	egistrar's Sign	nation	carles	)	nasil	LUGL	ULL U	··· 20	O T O		
	Regist		MAY 2	0 20	105	en .	15 19									

			State of Maryland / Department of Health and M  1 - State Registrar Certificate of Death		iefie) () 5 eg. No.	18854
	Physici	an	1. Decedent's Name (First, Middle, Last)  Myzlog, Hongy, Ougil Te	2. Date of Deat Month	Day Year	3. Time of Death
	/Medic	al	Myles Henry Quail, Jr.  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	may 1	4c. County of Deat	12,43 FT M
	Examin	er	Morth Armalel Hospital Glan Burns	6	Anna	Armdel
	Funeral Director		5. Social Security Number 313-30-1109 6. Sex 1 Months 1 M	8. Date of Birth (Month, Day) Sept. 1.	9. Birt Co 3, 1925 Mar	hplace (State or Foreign untry) Cyland
	yland Now		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	e Mar 3e-f sh tifted	ctor	South Carolina Horry Surfside Beach			1 □ Yes 2 XNo
	with th	Dire	106. Street and Number 107. Zip Code 1711 Highway 17 S., Unit# 356 29575	1	Og. Citizen of What Co United Sta	·
99	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Items 23a or 28e-f show avant. The Medical Exerting must be notified at	y Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 ☑ Yes 2 □ No	pecify Yes or No- Pican, etc.)	14. Race - Ame Black, White Specify: Wh	ncan Indian, e, etc.
21215-0036	In 72 hours n "natural", fedical Exe	Completed by	15. Decedent's Education (Specify only highest grade completed)  16. Decedent's Usual Occupation (Give kind of work done during most of work life, DO NOT use retired)	king	16b. Kind of Business/	
212	ed within giene. er than "	Som	Elementary/Secondary (0-12) College (1-4or 5+) 1-4 Salesman		Federal Go	vernment
and	be filed ntal Hygi ed other avant, t	Be	17. Father's Name (First, Middle, Last)  Myles Henry Quail, Sr.  18. Mother's Nam  Mary	ne (First, Middle, I	Maiden Sumame) <b>Demers</b>	
Maryland	s 1 and 2 should by f Health and Ments item 27 Is marked othar treumatic a	J.	19a. Informant's Name/Relationship ( <i>Type, Print</i> )  James Keith Quail —son  19b. Mailing Address ( <i>Street and Number or Run</i> 8356 Gartelman Farm Dr		; City or Town, State, 2	Tip Code)
	of Health of Health fitem 27 r other tr		20a. Method of Disposition 20b. Place of Disposition (Name of cametary crematory or other place)	-	20c. Location - City or	
Baltimore,	Pages tment of tent: If it		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Metropolitan Crematory 5/2	21/2005	Alexandria	, Virginia
Bal	permit. Pages Department of Importent: If is any injury or once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Donald V. Borgwardt 4400 Powder Mill Ro			
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a consequence of):	or respiratory arr	est,	Approximate Interval Between Onset and Death
Ü	Examiner	_	Sequentially list conditions, I are leading to appropriate by the sequence of			one year
	xecuted and Il-transit	Examine	Tarly, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):			one year
68760,	icate be executed physician and s the burial-transit	dicalE	d			
.O. Box 6	that the death certificated by the attending posterior of detached for use as	Physician/Me	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of del Month	ivery Day Year
<u>α</u>	luires that t n signed by ild be detai	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to	× /
Vital Records,	The law requires that the te has been signed by the age 2 should be detache	completed		24a. Was a autops perform	sy prior to d	topsy findings available completion of cause of
/ita	Physician: this certificatal director, p	BeC	examiner? ( Heavital: Other)	th (Check only on	ne)	
of	ling After une	ıtlon; To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hospital: 1 Natural 5 Pending Investigation No. 1 No.		ence 6 Other (Specow injury occurred	cify)
Division	al or Attending s after death. sl Diractor: Afte ed in by the fune	Certification;	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St City or Town	reet and Number or Ru n, State)	ıral Route Number,
	Hospital 24 hours 2 Funerel stely filled	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the cred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
)	To the Hospital or I within 24 hours after To the Funerel Dira completely filled in b	Med	29b. Signature and title of certifier  M 1)  29c. License number  D 48 00 6	2	9d. Date signed (Month	n, Day, Year)
R	(8)		30. Name and address of person who a impleted cause of death (Item 23a) (Type, Print)  KOF 1 130 13 TEY, 301 Hospital Dr.	, 67 les	1 Burni	+, m) 2106
	Sta Registi		31. Date filed (Month, Day, Year) MAY 2 4 2005		<u>, , , , , , , , , , , , , , , , , ,</u>	,

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** May 2005 Roschuni 13 4:15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 12906 Sutters Lane Prince George Bowie If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Funeral Days Min. Months Hours 1 ☐ M 2 ☑ F 84 Director Florida April 264-26-8639 26, Usual Residence of Deceden death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State item 27 is marked other then "neturel", or items 23s or 28e-f show other treumetic event, If a Moulcal Exerciter must be notified at ☐Yes 2 ☐ No Director Maryland Prince George Bowie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12906 Sutters Lane 20720 U.S.A Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status s filed within 72 hours after de I Hygiene. other then "neturel", or Item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give Year or Dates: 2 3 ₩Widowed 4 Divorced Completed Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wil Department of Health and Mental Hygiens Importent: if item 27 is marked other the eny injury or qhectreumetic event Interior Decorator Decorating 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hubert Gilbert Della Maude Samuel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gilbert Roschuni / Son 12906 Sutters Lane Bowie, Maryland 20720 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Cemetery May 20, 05 Jacksonville, Florida 22. Name and Address of Facility Joseph Gawler's Sons, Inc., 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave. N.W. Washington, D.C. 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Pancreatic Cancer 2 Months /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit Due to (or as a consequence of): attending physician Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4☐ Pregnant at time of death 5 ☐ Other (specify) P.O. the detached 9 Unknown 9 Unknown been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 X No Hospitel or Attending Physicien: 24 hours after death. Funerel Director: After this certifice Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) ျှ 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marrier stated. 24 1 To the I within 2. To the F 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certif May 17, 2005 D-17605 who completed cause of death (Item 23a) (Type, Print) Suite 201 Clinton, Maryland 20735 M.D. 8926 Woodyard Rd J. Haidak, 31. Date filed (*Month, Day, Year*) **MAY** 1 9 2005 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2005 Physician 14, May 4:54 PM Edwin F. Ryden /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 18613 Phoebe Way Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 01/06/1910 9. Birthplace (State or Foreign Country) Iew York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 □ F 95 Yre 710-07-3965 New Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28e-f show the Medical Examinar must be notified at 1 Tyes 2 No Montgomery Gaithersburg Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23e or 20879 U.S.A. 18613 Phoebe Way death v by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 9 If Yes, Give Year or Dates: WWII Specify: White 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced "netural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ than Elementary/Secondary (0-12) Teacher Education other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) rait. Pages 1 and 2 should be file purment of Health and Mental Hyportrant: If item 27 is marked oth y njury or other traumetic eventy in jury or other traumetic eventes. Stella Pinkowski John Rydzynski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marie Ryden, Daughter 18613 Phoebe Way, Gaithersburg, Maryland 20879 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 05/20/2005 Alexandria, Virginia <sup>4</sup> ☐ Donation 5 ☐ Other (Specify) permit.
Deportra
Importa
any nju 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Ligensee 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the deam. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician ear disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner OPN rucc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit mari that initiated events resulting in death) Last the attending physician and Due to (or as a consequence P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1□ Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? for Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ page 2 should be 1 🗌 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Certification: To 1 🗌 Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. 1 Natural 5 Pending 1 🗌 Yes 2 No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 26033 Ridge Road, Damascus, Maryland 20872 Charles W. Karesh, MD, 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 20 2005 Registrar

	1	For State Registrar	State of Maryland			of Hea			giene Reg. No. /	1000	
hysicia /Medica	ın	Decedent's Name (First, Middle, Last) HERMAN L. STURZA	Ą						19, Day	2005 <sup>ear</sup>	1:30P. M
Examine		a. Facility Name (If not institution, give s Shady Grove Advent.	reet and number) ist Hospital		4b. City, 7	Town, or Loc OCKVI.	cation of Deat 11e	h		ntgomer	
uneral rector		6. Sex 062–16–3948 1  ∴ Social Security Number 6. Sex	7. Age (In yrs. Is M 2□F	_	If Under Months		Under 24 Hrs lours Min.		th 17, 192	9. Birth Cou Nev	place (State or Foreign intry) V York
a pa	o	Usual Residence of Decedent 10a. State 10b. County Maryland Montgomer	y	Town or Loc Kensin	gton		er Spri	ng			10d. Inside City Limits 1 ☐ Yes 2 No
be notifi	Director	10e. Street and Number 14801 P	ennfield Circ	1e#403	10f. Zip	Code 2	<del>0895</del>	20906	10g. Citize Uni.t	on of What Collection	untry? Ces
Importent: If tem 2/18 marked other titler. Iterurer, or tests 2-a or 2-a or and any injury or other traumatic event, the Musical Examiner rough be nutified at once.	2		2. Was Decedent Ever in U. Armed Forces? 1 XYes, 2 □ No If Yes, Give Year or Dates: WWII	S. 13. W	Vas Deced	dent of Hispa offy Cuban, N	nic Origin? (S Mexican, Puer Specify:	Specify Yes or Noto Rican, etc.)		. Race - Amer Black, White pecify:	
Applical Ex	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation	(Give I life. D	kind of wor OO NOT us	al Occupation rk done duri se retired)	n ng most of wo	orking		of Business/I	
vent, the	Be Com	17. Father's Name (First, Middle, Last)  Abe		Engin rza	eer		i. Mother's Na Anna	me (First, Middle	, Maiden S		overnment n
aumanc a	10	19a. Informant's Name/Relationship (Ty Evelyn Sturza –wif						tural Route Numl			Tip Code)
		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ R	201 5	Inne of Diago	sition /blas	ma of		Date	200 100	ation - City or	
any injury once.		21. Signature of Funeral Service Licens		D22	Name ar	nd Address	faward	t Funera oad Bel	al Hom	e, PA	
cian lical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	calons that caused the deat ne cause on each line.  Septimized the control of the		er the mod				arrest,		Approximate Interval Between Onset and Death
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for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fete 4 Pregnant at time of of 9 Unknown	aldeath 3	Ectopic p Other (s				2	3d. Date of de Month	livery Day Year
should be detached	by	Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	inderlying	cause given	in Part I.		_		o the cause of death? robably 4 Dunknown
page 2 since	Completed							24a. Wa au pe 1 🗌 Yes	opsy formed		utopsy findings available completion of cause of 2 No
funeral director.	To Be	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending	Hospital: 1941Inpatient 2 [ 28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury		Other 28c. Injury a Work?	4 Nursing	Home 5 Re 28d. Describ	sidence 6		ecify)
in by the f	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, st				28f. Location City or 1	(Street and own, State)	d Number or F	iural Route Number,
completely filled in by the	edical C	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone)	ysician: To the best of my kn iner: On the basis of examin and manner stated.	lowledge, deal lation and/or in	th occurrencestigation	d at the time on, in my opi	o, date and pla nion, death of	ice, and due to the courred at the time	ne cause(s) e, date and	and manner a place, and du	s stated. e to the cause(s)
Compl	Me	29b. Signature applittle of certifier	- mo		29	9c. License D.56	number 652			e signed (Mon	_
0)	tate	30. Name and address of person who of Matthew Police 31. Date filed (Month, Day, Year)  MAY 2 A 2005	ffenrath P. Registrar's Sign	MO	, Print) 990	) M	edical	(enter	Priva	, Ro	ckville, N

		1 - State Office Registrar  1. Decedent's Name		23a,27,28a-1 ]	Ce	rtificate o	r Death	2. Date of Dea		Year	3. Time of Dear
Physic /Medi			·	azar Natanea	l Sanc			MAY	27, 200	)5	1529 I
Exami	ner			e street and number) OSPITAL CENTER	R	4b. City, Town CHEVI	, or Location of Deat ERLY	h	PRII	y of Death NCE GE	ORGES
uneral irector		5. Social Security N 213-67-9 Usual Residence of	397	ex 7. Age (In yrs	s. last birthday, Yrs.	) If Under 1 Year Months Day			y, Year)	Coun	ace (State or For try) 1and
Mot		10a. State	10b. County	10c. C	City, Town or L	ocation		-		10	0d. Inside City Lir
Be-f s	Director	Maryland	<u> </u>	George's		River			<u>_</u>		1 ☑ Yes 2 ☐
st be n	al Dire	10e. Street and Nut 6708	<sup>mber</sup> Auburn A	venue		10f. Zip Code	9 20737		10g. Citizen of	What Coun JSA	try?
Department of health and Mental Hyglene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-1 show yinjury or other treumetic event, If e Musical Exerticet must be notified at once.	by Funeral	11. Marital Status  1 XNever Marr 3 Widowed	ried 2 Married	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	U.S. 13.	Was Decedent of If Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puer No Specify: Sal	Specify Yes or No- to Rican, etc.) Lvadoriar	Bla	ice - America ack, White, e ify: Whit	etc.
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ental riygie ked other 1 ic event, th	To Be Co		(First, Middle, Last n Sanche:			10116		me (First, Middle, Karen Sor	Maiden Suma		
item 27 is mar item 27 is mar other treumet	1		ame/Relationship ( n Sanche:	Type, Print) z (Father)		-	and Number or R Avenue, R				Code)
nt: If item ry or othe				Removal from State Ma	cemetery, cre	osition (Name of ematory or other p Nationa	olace)	Date 31/05	20c. Location Laure		wn, State
Importer any inju			uneral Service Lice		-	9013 Δnr	dress of Facility Renapolis Ro	ndon/Hal			me
aminer											
lan and urial-transit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	mmediate erlying rinjury	c							
the attending physiclan and the drough the defended for use as the burial-transit	<u>a</u>	if any, leading to in cause. Enter Unde Cause (Uisease or that initiated event resulting in death)  IF FEMALE: 23b. Was deceded in the past 12 1  Yes 2	mmediate erlying striping stri	c	equence of): gnancy etal death 3	□Ectopic pregna				ate of delive	ry Day Year
gned by the attending phy: be detached for use as the	by Physician/Medical	if any, leading to in cause. Enter Unde Cause (Disease of that initiated event resulting in death)  IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	mmediate ertying strijury s Last  nt pregnant 2 months?	c	equence of): gnancy stal death 3 f death 5	Other (specify,		23e. Did to	obacco use cor	lonth	Day Year
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deam. ctor: After this certificate has been signed by the attending phy. y the funeral director, page 2 should be detached for use as the	To Be Completed by Physician/Medical	if any, leading to in cause. Enter Unde Cause (Disease of that initiated event resulting in death)  IF FEMALE: 23b. Was deceder in the past 12 1  Yes 2  Unknown  Part II. Other signi	nt pregnant 2 months?	Due to (or as a constant of the constant of th	gnancy stal death 3 f death 5 esulting in the 28b. Time Injury 2:50	Other (specify, underlying cause  ant 3 DOA of 28c. Ir	given in Part I.  26. Place of De  Other: 4 \( \text{Nursing I} \)  Nury at  Vork?  \( \text{Yes} 2 \)  No	24a. Was autor, period to the control of the contro	obacco use cor Yes 2 (No an 24b ssy rmed? 2 (No one) dence 6 (O) now injury occu ian str Street and Num vn, State 6 70	Intribute to the superior to condeath?  Therefore (Specify irred by the ror Rural 8 Audit	Day Year  The cause of death  ably 4 Unkn  Dosy findings avail  Impletion of cause  2 No
reath. .ctor: After this certificate has been signed by the attending phy. y the funeral director, page 2 should be detached for use as the	Certification; To Be Completed by Physician/Medical	if any, leading to in cause. Enter Unde Cause (Disease of that initiated event resulting in death)  IF FEMALE: 23b. Was deceder in the past 12 1	erred to medical  No  ifficant conditions  ifficant	Due to (or as a consider.)  23c. If yes, outcome of pregation in the contributing to death but not recontributing to death but not reconsist and r	gnancy stal death 3 f death 5 esulting in the 28b. Time Injury 2:50 those farm, s critical and services are services and s	ont 3 DOA of 28c. In P M 1 threat, factory, officeth occurred at the	given in Part I.  26. Place of De Other: 4 \( \triangle \) Nursing I nury at Vork? \( \triangle \) Yes 2 \( \triangle \) No ce	24a. Was autop performent of the control of the con	obacco use cor Yes 2 (No an 24b ssy rmed? 2 (No one) dence 6 (Ot now injury occu ian str Street and Num vn, State 70 1e, Mar cause(s) and n	Intribute to the state of the s	Day Year  The cause of death ably 4 Dunkn by findings avail appletion of cause 2 No  The van Aven ated.
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State

Registrar

31. Date liled (Month, Day, Year)

MAY 2 3 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#28e, perME, G344, 6/30/05 II

State of Maryland / Department of Health and Mental Hygiene. 5

The Amend Item 28e per me, G844, 06/27/11/05/dbb Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 18 Day Month Year Maria H. Esperanza Sanches 0740 M 200,5 1084 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Prince pital Cheverly 6 corges rince 6 earge 105 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) El Salvador 7. Age (In yrs. last birthday) 6. Sex Social Security Number 8. Date of Birth (Month, Day, Year) Months 45 Days Hours 643-84-8056 1 □ M 2 1 F July 10, 1959 Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits 10a State 10h County 1 Yes 2 □ No Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20901 El Salvador 11200 Lockwood Drive, Apt. 1020 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2X Married 1\$\vec{\pi} Yes 2□ No Specify: El Salvadorian Specify: Hispanic 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 5th College (1-4or 5+) Child Care Provider Child Care 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Fransico Sanches Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12021 Galena Road, Rockville, MD. 20852 Abel Esperanza/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State El Cerrito Cemetery May 28, 2005 San Migel, San Jerardo \* 4 □ Donation 5 □ Other (Specify) Pope Funeral Homes 11315 Lockwood Drive 22. Name and Address of Facility 21. Signature of Funeral 0 wa 20904 Silver Spring, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Accident with Head Trauma Immediate Cause (Final disease or condition resulting in death) Motor Vehicle Due to (or as a consequence of) Sequentially list conditions, a try, leading to minimulate cause. Enter Underlying Cause (Disease or injury b. Due to for as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Cther (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1- Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1₽Yes 2 No 28d. Describe how injury occurred STMLK 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death VAN while erossing street 1 Natural 5 Pending 2213M MAY 14 2005 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined

281. Location (Street and Number or Rural Route Number, City or Town, State) New Hampshee Arms & Lockword Drive

29d. Date signed (Month, Day, Year)

**Examiner** Box 68760 pe P.O. Records, Division of Vital Hospital or Attanding death.

**Physician** 

/Medical

Examiner

Director

Completed by Funeral

Be

2

Examiner

Physician/Medical

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Completed

2

Certification:

Medical

3 🖺 Suicide

29a. Certifier

4 Thomicide

(Check only one)

29b. Signature and title of certifier

**Funeral** 

Director

7 is marked other than "natural", or itams 23a or 28a-f show traumatic event, the Mudical Examination was be notified at

the Maryland

death

72 hours after

e filed within 7 al Hygiene.

1 and 2 should be fill Health and Mental H em 27 is markad ott

permit. Pages 1 and 2...
Department of Health au Important: If itam 27 is any injury or other trau

Physician

/Medical

attending physician and for use as the burial-transit

the

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page 2

certificate

this

After

Director:

Baltimore, Maryland 21215-0036

24 hours a 100 ti la within To the 2

State Registrar

Registrar's Signature 31. Date filed (Month, Day, Year) MAY 2 3 2005

3001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Road

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

150

Street

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 — indicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

140055 92

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May **Physician** 2005 Lillian 16, Springer 9:15 ΡМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Potomac Valley Nursing Center Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2**X**) F Director 75 Yrs. 29,1930 151-22-7712 New Jersey Usual Residence of Decedent nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland arment of Health and Mental Hygiene. orient: if item 27 is marked other then "neturel", or items 23a or 28e-f show innury or other treumatic event, the Medical Evarinar must be notified at a. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No **Burlington** Maple Shade 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 314 East Center Ave. 08052 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Bindery Worker Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Kilroy Agnes Bates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 08052314 East Center Ave. Maple Shade, New Jersey Jeffery Springer (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 23, Department Department Importent: If any in ury or once. 2005 Cherry Hill , NJ. <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) Colestown Cemetery 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licenses 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardio Pulmonary Failure Immediate /Medical Due to (or as a consequence of): **Examiner** Septic Shock 1 Day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed the burial-transit Thrombocytepemia 2 Weeks Due to (or as a consequence of) physician Division of Vital Records, P.O. Box 68760 Physician/Medical Hypertension 2 Years IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2X No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has 2X No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 🕱 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 2 1 ☐ Yes 2X No 2 ☐ ER/Outpatient 3 ☐ DOA this a after death.

I Director: After this id in by the funeral d 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. To the 29c. License number 29b. Signature and title of 29d. Date signed (Month, Day, Year) D59281 May 17, 2005

State Registrar 31. Date liled (Month, Day, Year) MAY 1 9 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



			For State Ragistrar	State of I	Maryland / Dep <i>Ce</i>	artment ertificate			and M	•	giene Rag. No.	200	The sage	10000
	Dhuaisi		1. Decedent's Name (First, Middle,	Last)						2. Date of De Month	ath Day	Ye		3. Time of Death
	Physici /Medio		Priscilla J. Sc							May 16,	200	5		8:30pm M
	Examin	er	4a. Facility Name (If not institution,		er)			Location of	of Death			4c. County of Death		
			9210 Kentsdale 5. Social Security Number		Age (In yrs. last birthday	Poton		If Under	24 Hrs.	8. Date of Bir		ntgom		ne (State or Foreign
	Funeral Director		001-12-0161 Usual Residence of Decedent	1 ☐ M 2 🖾 F	83 Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da Aug. 22	y, Year) 2, 19	21 T	Country	ee (State or Foreign )
	within 72 hours after death with the Maryland ene. than "natural", or itams 23e or 28e-f show than "Madical Examilian must be notified at		10a. State 10b. County		10c. City, Town or L	ocation							10d	. Inside City Limits
	be filed within 72 hours after death with the Marylan ital Hygliene. Id othar than "natural; or itams 23e or 28e-f show event, the Medical Examination must be notified at	Director	Maryland Montgo	mery	Potomac	<del></del>								1 ☐ Yes 2 🖾 No
	with the	Dire	10e. Street and Number			10f. Zip						en of What	Í	
	ns 23	Funerai	9210 Kentsdale	Drive 12. Was Decede	ent Ever in U.S. 13	208 Was Decede		spanic Orig	nin? (Spe	ecify Yes or No		ed St. 4. Race - A		
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ğ	ours a	l by	3	If Yes, Give Year or Date		1☐ Yes 2	No REL	Specify:				Specify: W	hite	
Maryland 21215-0036	72 h	Completed	15. Decedent's (Specify only highest	Education grade completed)	(Giv	edent's Usual e kind of work	k done d	lurina mosi	t of worki	ng	16b. Kir	d of Busine	ss/Indus	stry
2	within ane. than	mp	Elementary/Secondary (0-12)	College (1-4e	or 5+)	DO NOT us					αL			
Q Q	lied tygii thar nt, t	ပိ	17. Father's Name (First, Middle, L.	<u> </u>	Urg	anic (	nem		r's Name	(First, Middle,		emist Sumame)	ry	
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Ξ	and 2 saith a n 27 is ar tre		Deborah Schuman	n (Daught				11 Te	rrac	e, Beth	esda	, MD	2081	6
ore	of He		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 □Removal from Sta	20b. Place of Disp	osition (Nam	e of			ate		ation - City		
Ě	Pages ment of l	07	* 4 ☐ Donation 5 ☐ Other (Spe	ecify)	Metropo1	itan C	rema	atory	5/1	7/05	Alex	andria	a, V	irginia
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menia Importent: If item 27 is marked any injury or pathar treumatic a once.		21. Signature of Euneral Service Li	Delet	2	2. Name and 10 Eas Gaithe	Addres t De rsbu	s of Facilit eer P urg,	y De ark MD 2	Vol Fun Drive 0877	era1	Home		
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	Physician		Immediate Cause (Final disease or condition	Ather	osclerosis								0	nset and Death
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Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		n 2 Fetal death 3	□Ectopic pre					2	3d. Date of	delivery Da	y Year
0	at the de by the a tached f	ysic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4∐Pregnan 9☐ Unknow		Other (spe	ecify)							7
ري م	w requires that been signed b should be deta	by Pi	Part II. Other significant condition	s contributing to deat	th but not resulting in the	underlying ca	use give	n in Part I.		23e. Did to	obacco us	e contribute	to the o	cause of death?
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ecords,	law re as be 2 sho	Completed								24a. Was		24b. Were	autopsy	findings available etion of cause of
		Corr									rmed?	death	? 'es 2[	
Vital	sician: The law certificate has b irector, page 2 s	Be	25. Was case referred to medical examiner?	l Hannah			0.1			(Check only o				
ō	Physi this c	. To	1 ☐ Yes 2 🔀 No 27. Manner of Death	Hospital:			A Othe	or. 4 □ Nu		ne 5 🔀 Resid			pecify)	
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Division of	Attandi death. ctor: A y the fu	fica	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place of	Injury - At home, farm, s				-	28f. Location (5	Street and	Number or	Rural R	oute Number,
2	al or / s after I Dira d in b	Certification;	4 Homicide	building,	, etc. (Specify)	,,				City or Tox	vn, State)			
	To the Hospital or Attanding Physician: within 24 hours after deals.  To the Funaral Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier (Check only one) 1 X Certifying 2 Medical E	Physician: To the be xaminer: On the basis	est of my knowledge, dea is of examination and/or in	th occurred anvestigation,	t the tim	e, date and pinion, deat	d place, a	and due to the e	cause(s) a date and	and manner place, and c	as state	od. e cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	01		29c.	License	number			29d. Date	signed (Mo	onth, Day	y, Year)
			1740	VI	1~	R	141	124	1		2	. 1"	7.	2005
	10		30. Name and address of person w	no completed cause of	of death (Item 23a) (Type			-						
			Jack R. Epstein,			cut Av	zenu.	e, Ke	nsin	gton, N	1D 20	895		
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 9 2	005 Reg	istrar's Signature	who .								

			1 = For State Registrar				of Health a	nd Mental Hy	giene 2 n	05 I	0000
			Registrar  1. Decedent's Name (First, Middle, Last)			Certificate	UI Dealli	2. Date of De	Reg. No. — U	3 Tim	e of Death
	Physici	an		ment G. Sce	asha als			Month	Day	Year	
<b>K</b>	/Medi Examir		4a. Facility Name (If not institution, give s		STRUCK	4b. City, To	own, or Location of	May Death	4c. County of		03 A <sup>M</sup>
	LAdiiii	iei	12290 Green Meadow		)3	Col	umbia		Howar	rđ.	
	Funeral		5. Social Security Number 6. Sex	7. Age (	In yrs. last bir	thday) If Under 1		Min. 8. Date of Bi	rth	9. Birthplace (Sta Country)	te or Foreign
45.	Director		300 16 3644	<sup>M</sup> <sup>2□</sup> F 83		Yrs.	Days	May 6	1922	Ohio	
	pur *		Usuat Residence of Decedent  10a. State 10b. County	1	0c. City, Tow	n or Location				10d Insid	e City Limits
	Mary!	ō	MD Howard			mbia					Yes 2 No
	the 288-	Director	10e. Street and Number			10f. Zip C	Code		10g. Citizen of W	hat Country?	
	3a or		12290 Green Meadow	Drive #70	13		21044		Unito	d States	•
	death	Funeral		12. Was Decedent Eve Armed Forces?				in? (Specify Yes or No Puerto Rican, etc.)		- American Indian	
9	or ite	F.	1 ☐ Never Married 2 ☑ Marned	1⊠Yes 2 □ No If Yes, Give		1 Yes 2		r dente ritean, etc.)	Specity:	k, White, etc.	
21215-0036	ural',	d by	3 Widowed 4 Divorced	Year or Dates: 1 S						wnite	
15	n 72 ł	Completed	15. Decedent's Educ (Specify only highest grade	ocompleted)	16a.	Give kind of work life. DO NOT use	done durina most	of working	16b. Kind of Bus	iness/Industry	
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D	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or Items 23e or 28e-f ehow event: tre Mcdreil Exemiter trust be recitied at	Be C	17. Father's Name (First, Middle, Last)					's Name (First, Middle			
<u>a</u>	Aenta Aenta rked ric ev	To B	Michael Scerback				Anna	Harmagy			
Maryland	and A		19a. Informant's Name/Relationship (Ty)					or Rural Route Numb			
	and and n 27		Wilma C. Scerback/					Drive #703			
ore	pes 1 t of H If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ R	BITTUVALITUTI STATE		Disposition (Name ry, crematory or oth		Date		City or Town, State	
Ë	tmen tant:	27	* 4 □ Donation 5 □ Other (Specify)			Crematory		5-20-2005		ille, MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event. It a Marical Examiner must be notified at once.		21. Signature of Funeral Service License	P DO N	101044			Harry H. W a Pike Ell			
			23a. Part 1. Enter the disease, or compli	cations that caused th	e death. Do					Approxi	
			shock, or heart failure. List only on Immediate Cause (Final	ne cause on each line.						Interval	Between nd Death
4	Physician /Medical		disease or condition resulting in death)	Due to (or as a	SCIM	MC CATE	When	ro Per		grs	
	Examiner			200 (0) (0) 43 4 0	DAIM	- Arote	1) (xum	ast .		Who	
1		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequende	ol):	) Mars				<u></u>
	ocuted nd transi	Examiner	triat initiated events	:							
,092	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit		resulting in death) Last	Due to (or as a c	onsequence	of):					
687	physic the b	dical		l							
9 ×	ding	Physician/Med	IF FEMALE:	3c. If yes, outcome of	pregnancy				and Date	of delivers	
Вох	atten for u	clan	in the past 12 months?	1 Live birth 2 [ 4 Pregnant at tim	Fetal death	3 ☐Ectopic preg 5 ☐ Other (spec			Mont	of delivery th Day	Year
P.O.	the d ny the ached	Jysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown							
٠ <u>,</u>	Attanding Physicien: The law requires that the death certifica r death.  actor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as it.	by PI	Part II. Other significant conditions con	tributing to death but r	not resulting in	the underlying cau	use given in Part I.	23e. Did	obacco use contrib	oute to the cause	of death?
rd	w requires that been signed be should be deta	ed b	1)10Rets					1 🗆	Yes 2 □ No 3	3 ☐ Probably 4	Unknown
000	aw re	Completed	, ,					24a. Was		ere autopsy findin	
Ä	The lay ate has bage 2	E O						perfo	ormed? de	ior to completion o eath? ⊒ Yes 2 ⊊ No	ir cause or
ita	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place	of Death (Check only		X	
<u>~</u>	Phyeic this ce al dire	은	1 ☐ Yes 2ਉ No	lospital: 1   Inpatient	2 ER/Ou	tpatient 3 DOA	Other: 4 Nurs	sing Home 5 🔀 Resi	dence 6 Other	(Specify)	
ב	ing P	on:	27. Manner of Death  1 ☒ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y		njury	c. Injury at Work?		how injury occurre	d	
Sic	ttand death ttor; / the f	cat	2 Accident investigation 3 Suicide 6 Could not be	On Diago of Injury	A1 h 1-	M	1 ☐ Yes 2 ☐ N		Street and Number	r or Down I Down A	f ha .
Division of Vital Records,	or A after Dirac	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (	Specity)	rm, street, ractory, o	οπισθ	City or To		or Hurai Houte N	итрег,
_	To the Hospital or Attanding Physician: The I within 24 hours after death.  To the Funeral Director; After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 **Certifying Phys	sician: To the best of r	ny knowledge	, death occurred at	the time, date and	place, and due to the	cause(s) and man	ner as stated.	
	e Ho	Medical	(Check only 2 Medical Examir	ner: On the basis of ex and manner stated	amination an	d/or investigation, in	n my opinion, death	occurred at the time,	date and place, ar	id due to the caus	e(s)
	To th To th comp	Ň	29b. Signature and title of certifier			29c. 1	License number		29d. Date signed	(Month, Day, Year	9
,			Xta Kotall	$U\Lambda$		1)	-3486	8	May 20	0, 2005	
100	<del>-</del>		30. Name and addr as of person who co	mp ted cause of deat	h (Item 23a)	(Type, Print)	001-	1. Ou 1.	May 20	1411	
10			31 Date filed (Marth Dr. Van)	Wr 20 D	11011	Ultte	2 1/2/12/40	AT PIL C	surhor /	MM SIM	4
	Sta Registi		31. Date filed (Month, Day, Year)	32. Resistrar's	Signature	how H.					

		-	State of Maryland / Department of Health and last terms of State of Maryland / Department of Death		ne 005	18864
			1. Decedent's Name (First, Middle, Last)	2. Date of Death Month		3. Time of Death
	Physicia /Medic		Roy Thompson	MAY	18 2009	
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  WINERSTY OF MARYLAND HOSPITAL  BYTTHERE	n	4c. County of Dea	
H	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	9. Bin	thplace (State or Foreign
	Director		240–66–2692 1A Yrs. 63	NOVEMBER 10	0.1941 <b>NORI</b>	H CAROLINA
	land ow	-	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits
	a-fsh	ctor	MARYLAND PRINCE GEORGES FORT WASHINGTON			1 XYes 2 No
	vith the	Director	10e. Street and Number 10f. Zip Code 8903 LOUGHRAN ROAD 20744		i. Citizen of What Co NITED STA	1
	death with the Maryland ms 23a or 28a-f show	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No-	14. Race - Ame	erican Indian,
30	be filed within 72 hours after death with the Marylan by lygiene. d a hygiene. d other than "natural", or Items 23a or 28a-f show event, I're Madical Exercitrational barrowillied at	by Fun	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No	to Rican, etc.)	Specify: R	e, etc. LACK
15-0036	2 hour		15. Decedent's Education 16a. Decedent's Usual Occupation	16	b. Kind of Business	
212	within 72 ene. than "nat	Completed	(Specify only highest grade completed)  (Give kind of work done during most of wo life. DO NOT use retired)  Elementary(Secondary (0-12) College (1-4or 5+)	rking	RETAIL	
7	filed w Hygien other th		12TH GRADE RETAIL SALES  17. Father's Name (First, Middle, Last)  18. Mother's Nai	me (First, Middle, Ma		
aryland		To Be		CANNON THO		NKLIN
ary	d 2 should be I th and Mental I 7 is marked o traumatic eve	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Re			
≥	5 = 7 T		MILDRED C. THOMPSON / WIFE 8903 LOUGHRAN ROAD, FO			
altimore,			1 ABurial 2 Cremation 3 Removal from State		c. Location - City or UITLAND,	
Ħ	permit. Pages Department of I Important: If ite any injury or of		21. Salving of Funderal Serving Censes 22. Name and Address of Facility THORNION FUNERAL HOME,		orimmo,	IMITANI
ň	Ped Land		LIDIA C. THORNTON JOHNSON MOO583 3439 LIVINGSION ROAD,	INDIAN HEAD,		20640
ď			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	c or respiratory arres	t.	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. LEACOLIC ANASTMOSIS LEAK			
	Examiner		Due to (or as a consequence of):  COLON CANCER			2 HONTHS
	n =	ner	Sequentially list conditions, if any, leading to infinited are cause. Enter Underlying Cause (Disease or injury			
	and transi	Examine	Cause (Disease or injury that initiated events c.  Cusulting in death) Last  Due to (or as a consequence of):			
8760,	cate be executed physician and the burial-transit	dicai E				
9	tificate ig phy as the	a)				
Вох	death certificate be executed e attending physician and ad for use as the burial-transit	ian/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Livre birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of de Month	livery Day Year
0	at the dea by the a tached f	Physici	# The past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  4 ☐ Pregnant at time of death 5 ☐ Other (specify)			
<u> </u>	res that tigned by	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute t	the cause of death?
ords	w require been sig should b	ted t		1 Tes	2 <b>5</b> √No 3 □ P	robably 4 Unknown
Records,		Completed		24a. Was an autopsy performe	24b. Were a prior to death?	utopsy findings available completion of cause of
			25 West and the state of the st	1 ☐ Yes 2	No 1 ☐ Yes	2 □ No
Viital	S S	o Be	examiner?	ath <i>(Check only one)</i> Home 5 🗆 Residen	ce 6 □Other (Spe	ecity)
Division of	a = a	n: T	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?	28d. Describe how		
Siol	tendir leath. tor: Af the fu	catic	2 Accident investigation M 1 Yes 2 No	281 Location /Stro	et and Number or R	um I Pouto Number
Ω	or Attend after death Director:	Certification;	4 Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town,	State)	uraj nobile ivaliloer,
	To the Hospital or Attending i within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier (Check only 2   Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occ	e, and due to the cau urred at the time, date	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	o the inthin 2 o the l	Med	one) and manner stated.  29b. Signature and title of certifier 29c. License number	290	J. Date signed (Mon	th, Day, Year)
•	⊢ ≤ ⊢ ŏ		ROSIDENT PHYSICIAN AU4176435W	15216 M	A4 18, 2	2005
ſ	11P 16		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  RICHARD WOOD 22 S. GREENE STREET BATTING	re mo	21201	
	Sta Registi		31. Date liled (Month, Pax, Year) NAY 2, 0 2005 Signature			
	negisti	1				

			For State Registrar	State of	Marylar	-	artment rtificate			and M	_	giene Reg. No.	5 10	3865
	Physici	an	Decedent's Name (First, Middle, Last								2. Date of De Month	Day Ye	ar	ne of Death
	/Medic Examir	cal	Marie B. Townsend  4a. Fecility Name (If not institution, give		ber)		4b. City, T	Town, or	Location of		May 18,	4c. County of D		:40pm <sup>M</sup>
	LXaiijii	161	Casey House				Rock					Montgome	ry	
	Funeral		5. Social Security Number 6. Se	x 7		last birthday) Yrs.	If Under	1 Year Days	If Under:	Min.	8. Date of Bir (Month, Da	y, Year)	Birthplace (Sta Country)	
	Director		Usual Residence of Decedent		79				1		June 14	, 1925 Co	nnecti	cut
	arylan show	-L	10a. State 10b. County			ty, Town or Lo								de City Limits Yes 2 □ No
	the M	recto	Maryland Montgome  10e. Street and Number	ry	Gai	thersb	urg 10f. Zip	Code				10g. Citizen of Wha		
	th with	Funeral Director	401 Belle Grove R	.oad			208	377				United St	ates	
	er dea	uner	11. Marital Status	12. Was Deced	es?	I.S. 13.	Was Decede	ent of Hi ify Cuba	spanic Orig n, Mexican	gin? (Spe n, Puerto f	cify Yes or No Rican, etc.)	- 14. Race - A Black, V	American India Vhite, etc.	ın,
920	72 hours after death with the Maryland natural', or Hems 23a or 28a-f show deat Extended out the notified at	þ	1 Never Married 2 Married  3X Widowed 4 Divorced	1 Tes 2 If Yes, Give Year or Dat			1 ☐ Yes 2	X No	Specify:			Specify:	White	
215-0036	72 ho	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)		(Give	dent's Usual kind of worl	k done a	lurina most	t of workir	ng	16b. Kind of Busine	ess/Industry	
2121	within the	dwo	Elementary/Secondary (0-12)	College (1-	4or 5+)	Super	DO NOT us visor	e retirea,	,			Phone Com	nany	
nd 2	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, It e M.	BeC	17. Father's Name (First, Middle, Last)			Duper	VIBOL		18. Mothe	r's Name	(First, Middle,	Maiden Sumame)	party	
Maryland	should be and Mental I marked o	To	Joseph Botte								Pace11			
Mai	nd 2 sh lth and 27 Is n r traum		19a. Informant's Name/Relationship (T		(Son)	2						er, City or Town, Sta Sburg, MD		
Je,	of Health litem 27		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nam	e of			ate	20c. Location - City		te
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Heath and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23a or 28a-f show any night or other traumatic event, its Medical Existinar mat be notified at DDCs.		1 ☐ Burial 2 ত Cremation 3 ☐ 1 ☐ Other (Specify)	)								Alexandri	a, Vir	ginia
Bai	permit. Pages Department of Himportent: If ite any injury or ot once.		21. Signature of Funeral Service Licens	621/0			Name and Enst					ral Home		
	10.00		23a. Part1, Enter the dise se comp shoot, or heart failure. List only of	elications the ca	used the deat							rest,	Approx	imate I Between
	Physician	П	Immediate Cause (Final disease or condition resulting in death)	a		SX	oke						Onset a	and Death
	/Medical Examiner	П	resulting in death)	Due to (o	r as a consec	quence of):								
	7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (o	r as a consec	quence of):								
	The law requires that the death certificate be executed tte has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Examiner	cause. Enter Underlying Cause (21sease of hijusy that initiated events resulting in death) Last	c	r as a consec	ruence of):				-				
8760,	ate be ex hysician he buria			d.	. 40 4 0011000	400.00 0.7.								
.89	rtificate ng phys as the	Physician/Medical	IF FEMALE:											
Вох	leath certifica attending ph I for use as th	lan/	23b. Was decedent pregnant in the past 12 months?		ome of pregnath 2 ☐ Feta nt at time of c	al death 3	Ectopic pre					23d. Date of Month	delivery Day	Year
o.	that the de ned by the a detached f	hysic	1 Yes 2X No 9 Unknown	9 Unknov		30aii 31	1 Other (spe	ciiy)						
S, P	res tha igned l be det	by	Part II. Other significant conditions co	ontributing to dea	ath but not res	sulting in the u	nderlying ca	use give	n in Part I.			obacco use contribut		
Records,	w requir been si should	eted	Coronau	0.6	recy	0000	lain	23-6			1 [] `			4 []Unknown
Rec	The lav	Completed	Irace	2001	~~		(W)				autor perfo	psy prior deat	e autopsy findii to completion h? Yes 2□ No	of cause of
/ital	(0)	BeC	25. Was case referred to medical examiner?								1 ☐ Yes (Check only o	ne)		
of Vital	Physician: this certificatal director, participate in the control of the control	P	1 ☐ Yes 2 No 27. Manner of Death			ER/Outpatier						dence 6 Other	Specify) Cel	trospico
ion	Attending F r death. ector: After by the funera	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of (Month	, Day Year)	Injury	м	Sc. Injury Work	k? Yes 2⊡I			ion injury occurred		iii
Division	or Atterde terde virecto	Certification:	3 Suicide 6 Could not be 4 Homicide determined	289. Place 0	of Injury - At h g, etc. (Speci	ome, farm, str fy)	eet, factory,	office		2	8f. Location (: City or Tox	Street and Number o vn, State)	r Rural Route I	Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely illed in by the funeral director.		29a. Certifier 12 Certifying Phy	ysicien: To the t	pest of my kno	owledge, deat	h occurred a	it the tim	e, date an	d place, a	nd due to the	cause(s) and manne	r as stated.	
	To the Hos within 24 h To the Fur completely	Medical	(Check only one) Medicel Exem	iner: On the bas and manne	sis of examina	ation and/or in	vestigation,	in my op	oinion, dea	th occurre	d at the time,	date and place, and	due to the cau	1Se(s)
	To t To t	Σ	29b. Signature and title of certifier	DA.	11 17	Cinn -	29c.		number	30		29d. Date signed (M	onth, Day, Yea	ar)
	12		30. Name and address of person who d	completed cause	of death (Iter	m 23a) (Type	Print)	レ	, 2	10	2	May 1.	Rock	4(00
_			DR A MEN	DHIR	APP	A 2	401	Re	ear	rch	BUND	Suite 3.	30 001	028650
::	Sta , Regist	ate rar	31. Date filed (Month, Day, Year)  MAY 2 0 20		gistrar's Sign	ture for	ule							

		Pleas	se Type or	Prir	nt in E	Black	k Ind	delible	e ink	. Ensi	ure Al	II Copie:	s A		ble.	
	For State Ragistrar					d/D	)epa	ırtmen	t of F		and M	lental Hy		ene		
n	Decedent's Name		<i>Last)</i> Robinson	Wi	llian	ns						2. Date of D Month May	eath 19	Day 20	Year 05	3. Time of Death
r	4a. Facility Name (If Sunbridge		give street and nu Rehabilitat	Facil:	ity		4b. City,		r Location kton	of Death			4c. County	of Death Cec:		
	5. Social Security No. 217-60-4	hday) Yrs	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of B (Month, D Dec.	av. Y	9 <i>ar)</i>	Cou	place (State or Foreign intry) insylvania					
ŗ	Usual Residence of 10a. State Maryland	10b. County	ecil		10c. City	, Town	or Loc		nov	ingo						10d, the City Limits 1 ☐ Yes 2 ☑ No
II Director	10e. Street and Num 61 Dutch	nber						10f. Zip		2191	8		10g	. Citizen of V	Vhat Cou	•
Dy Funeral	11. Maritat Status 1 □ Never Marrie 3 ☒ Widowed		12. Was Dec Armed Fo 1 Yes If Yes, Gi Year or D	orces? 2 🔯 N		S.	S. 13. Was Decedent of Hispanic Origin? (Spin If Yes, specify Cuban, Mexican, Puerto								k, White	ican Indian, , etc. hite
ompieted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)							ent's Usua kind of wo OO NOT us	rk done	during mos	st of work	ing	161	b. Kind of Bu	isiness/li	ndustry
Ę	Twelve Years						Homemaker Personal F					Residence				
17. Father's Name (First, Middle, Last)  William Slater Robinson										18. Moth		e <i>(First, Middle</i> Lulu N:			e)	
	19a. Informant's Name/Relationship (Type, Print) 19b. M						Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hopewell Cemetery

OM

**Physician** /Medical

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel" ~ "" any injury or other fraumatic even."

**Physicia** 

/Medic Examine

**Funeral** Director

Examiner

Division of Vital Records, P.O. Box 68760,

23a. Part1. Enter the disease, or compli-shock, or heart failure. List only or tmmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical IF FEMALE: 2 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ Ho 9 Unknown 25. Was case referred to medical examiner?

1 Yes 2 4 Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 5 Pending 2 29

Linda W. Ward (Daughter)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

1 Burial 2 □ Cremation 3 □ Removal from State

20a. Method of Disposition

cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory to cause on each tine.  Metastatic Brain Cancer	Interval Between
Due to (or as a consequence of):	
Due to (or as a consequence of):	
Due to (or as a consequence of):	Assessment of the second of th
3c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)  9 Unknown	23d. Date of delivery Month Day Year

45 Palo Lane, Newark, Delaware

22. Name and Address of Facility Lee A. Patterson

Date

05/24/05

Perryville, Maryland 21903-0766

20c. Location - City or Town, State

& Son Funeral Home, P.A.

Port Deposit, Maryland

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1□ Yes 2 1 No 26. Place of Death (Check only one) Other: 4 ☐ Hursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

2 Accident	mrv Cottgation		
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number City or Town, State)
			V
9a. Certifier	1 Certifying Physi	cian: To the best of my knowledge, death occurred at the time, date and pl	ace, and due to the cause(s) and manner as stated.

1		00 1:	
(Check only one)	2 Medical Examiner: On the basis of examination and/o and manner stated.		
Ja. Obilliel	Territying rifysician: To the best of my knowledge, di	eath occurred at the time, date and place, and due to	the cause(s) and manner as stated.

b. Signature and title of certifier	29c, License number	29d. Date signed (Month, Day, Year)
Klo-Si- MI	DD056449	5/20/09,
Name and address of person who completed cause of death (Item 23a) (Type, Proceedings of the Company of the Com	West High St. Su	te 302 MD 2192
Date filed (Month, Day, Year)  MAY 2 3 2005  Registrar's Signature	W	/

State Registrar

31. Date filed (Month, Day, Year)
MAY 2 3 2005

			1 - For State Registrar	State of M	laryland		artmen			d Mental I	Hygien	ZUIIA	18867
			1. Decedent's Name (First, Middle,							2. Date of	Death		3. Time of Death
	Physic /Medi		Sally	William	75					Month	V 16		5 12:39 AM
	Exami	ner	4a. Facility Name (If not institution, g		)		4b. City,		ocation of De		_	. County of Deat	th
			P.G. Hospita		an (la um la	ne bint day	If Under		erly If Under 24 F	Jen To o		Prince	George's
	Funeral Director		225-32-5752	1 □ M 2 □ XF	ge (In yrs. Ia 79	Yrs.	Months	Days		in. (Month,	Day, Year,		hplace (State or Foreign buntry)
	D		Usual Residence of Decedent							sep.	14, 1	923 \	Virginia
	arylar show	_	10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	Ra-f	Director	DC				· · · · · ·		shingt	on	-1		1 ŽiYes 2 ☐ No
	with t	늄	10e. Street and Number 410 M St.	C F #/	106		10f. Zip		20002		10g. Ci	tizen of What Co	
	death	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	. 13. V	Vas Deced		20003	(Specify Yes or	No-	United 14. Race - Ame	
9	after or Ital	F	1 ☐ Never Married 2 🔀 Married	Armed Forces	? No	II				(Specify Yes or erto Rican, etc.)	110	Black, White	9, etc.
933	ural',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			☐ Yes 2	2LXLNo	Specify:			Specify: I	Black
15-	"natu	Completed	15. Decedent's (Specify onfy highest of	Education grade completed)		16a. Deced	lent's Usua kind of wor	l Occupati k done dui	on ring most of v	vorking	16b. K	ind of Business/	Industry
12	withii ene. than	ᇤ	Elementary/Secondary (0-12) 7th	College (1-4or	5+)	me. L	Foste					C = ==	
b	be filed within 72 hours after death with the Maryland nat hygiene.  34 other than "natural", or Itams 23a or 28a-1 show avent, I've Medical Examinar must be recified at	Be C	17. Father's Name (First, Middle, La	st)			10500			lame (First, Mid	dle, Maiden	Govern	ıment
/lar	should be filed withir nd Mental Hygiene. marked othar than imatic avant, the M	To B	Gilbert E <sub>I</sub>	ps						A	nnie (	Campbell	_
Maryland 21215-0036	N 8 8 1		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address	(Street and	d Number or	Rural Route Nu	mber, City o	or Town, State, Z	lip Code)
	1 and 2 Health tam 27 i		Joseph William	ns - Husban		410	M St	. , S	.E. #	406. Wa.	sh., i	OC 2000	3
Baltimore,	of of		20a. Method of Disposition 1   Burial 2 □ Cremation 3		сеп	ce of Dispos netery, crem	atory or oti	her place)	ļ		20c. Lo	ocation - City or	Town, State
표	permit. Pag Department Important: f any injury o		4 □ Donation 5 □ Other (Special Signature of Fune)al Service Lic	**	Line		lemori			20/2005		Suitland	
Ba	permit. Departn Imports any inju		la l	Stours	VIII				-,			eral Hom , DC 20	
	4		23a. Part1. Enter the disease, or co shock, of heart failure. List on	mplications that cause	d the death.							, 20 20	Approximate
	Physician		Immediate Cause (Final disease or condition	y one cause on each	-	lan	fail	0.00					Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as			1011	u.e					
	Examine	_	Sequentially list conditions, if any, leading to immediate	b. Dreug									
	ted	Examine	cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	nce of):						- 1	
Ć	execu n and ial-tra	Exar	that initiated events resulting in death) Last	c. Due to (or as	a conseque	nce of):							
8760,	ficate be executed physician and s the burial-transit	dical		d									
9	ntifica ng ph as th	Medi	IF FEMALE:										
Вох	death certifica e attending ph of for use as th	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal de	eath 3 🗆	Ectopic pre	gnancy				23d. Date of deliv	,
0		ysic	1 Yes 2 No	4□Pregnant a 9□Unknown	t time of deat	th 5□	Other (spe	cify)			-	Month	Day Year
Ω.	requires that the een signed by th hould be detache		Part II. Other significant conditions	contributing to death b	out not resulti	ing in the un	derlying car	use given i	in Part I.	23e. Di	d tobacco u	se contribute to	the cause of death?
Records,	quires n sign lid be	Φ	£ (	ncer			, , ,					_	bably 4 Unknown
S	> 40 00	olete	SIP CVA							24a. W	as an	24h Ware aut	opsv findings available
æ	9 4 9	Completed			-					au pe	topsy rformed?	prior to co death?	ompletion of cause of
	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?					20	6. Place of D	1 ☐ Yes		1 🗆 Yəs	2□ No
of V	di S	To	1 ☐ Yes 25⊈No		ent 2 EP	VOutpatient	3□ DOA	04			111111111111111111111111111111111111111	S □Other (Speci	fy)
		on:	27. Manner of Death  1 ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28	8b. Time of Injury		c. Injury at Work?		28d. Describ			
Division	Attanding ar death. ractor: After by the funer	Certification;	2 Accident investigate 3 □ Suicide 6 □ Could not	be	At have	. 40.000	М		2 □ No	0011	<b>10</b> .		_
<u>&gt;</u>		ertif	4 Homicide determine	28e. Place of Inj building, et	c. (Specify)	e, rarm, stree	et, factory,	office		28f. Location City or 7	(Street and own, State,	d Number or Run )	al Route Number,
	a Hospital or Attano 24 hours after death Funeral Diractor: stely filled in by the		29a. Certifier Certifying P	hysician: To the best	of my knowle	edge, death	occurred at	t the time.	date and place	ce, and due to th	na causa(s)	and manner as s	stated
	To tha Hospital or within 24 hours afte To tha Funeral Dir. completely filled in I	Medical	(Check only 2 Medical Exa	miner: On the basis of and manner sta	r examination	n and/or inve	stigation, i	n my opini	on, death occ	curred at the tim	e, date and	place, and due t	o the cause(s)
	To tha I within 2 To tha I complet	Σ	29b. Signature and title of certifier	0 0	1		29c.	License nu	umber		29d. Date	signed (Month,	Day, Year)
			Karen	K Bre	ON			000	164C	83	4	5/16/0	5
	73)		30. Name and address of person who	completed cause of d	eath (Item 23	3a) (Type, P	rint)	the-	0-1-	20	111-1-	11/ 11/	20785
	Sta	0	P.G. Hospital 31. Date filed (Month, Day, Year)	100	ar's Signature		2001	TIW	11147	ØK .	LHEVE	KH, MD	20/85
E	Registr		MAY 2 3 200		Ł	land	٠,						

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 13, 2005 **Physician** 9:17 p Sean D. Woods /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Civista Medical Center LaPlata, MD Charles If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Months Days 1 1 M 2 □ F 577-17-8734 Yrs Director 22 10, 1982 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic avant, the Medical Examiner must be notified at Maryland Charles Marbury 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ P.O. Box 243 or Items 23a 20658 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XNever Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: Specify: Specify: Black 3 Widowed 4 Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If itam 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Massage Therapist Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Fages 1 and 2 should be Robert H. Woods, Jr. Wanda F. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. U. Box 243 Marbury, MD

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date Wanda Woods/Mother 20658 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Harmony Memorial Park 5/20/05 4 □ Donation = 5 □ Other (Specify) Landover, Maryland 22. Name and Address of Facility
Alexander S. Pope Funeral Homes
5538 Marlboro Pike, Forestville, 21. Signature of Funeral Service License any 40108 20747 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Herrmorr ag disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attanding Physician: The law requires that the death certificate be executed burial-transit Olec P.O. Box 68760, attending physician 17 bout Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 120N 1 ☐ Yes 2 ☐ No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death Check onl one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 210 NO ☐ Impatient 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Anatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours at To the Funaral D 29a. Certifier f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of ceptifier 29c. License number 29d. Date signed (Month, Day, Year) D-47202 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pradip Sahdev, MD, 3450 Old Washington Rd., Waldorf, MD 20603 31. Date filed (Month, Day, Year) State MAY 2 3 2005 Registrar

			1- For State of Maryland / Dep. Registrer Ce	artment of Health and Natificate of Death	Mental Hygie	0000	10000
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  James Ray Wyatt		2. Date of Death Month May ! 8, 2	- <del> </del>	3. Time of Death 0120 <sub>M</sub>
	Examin		4a. Facility Name (If not institution, give street and number) Shady Grove Hospital	4b. City, Town, or Location of Death Rockville		4c. County of Death	
	Funeral Director		5. Social Security Number $\begin{array}{c ccccccccccccccccccccccccccccccccccc$	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Pay, Ye Feb. 7,	9. Birth	place (State or Foreign ntry) Sh., DC
	faryland ehow	or	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Li Md. Montgomery Roc	ocation kville			10d. Inside City Limits  Y Yes 2 □ No
	with the h	Funeral Director	10e. Street and Number 9701-Veirs Drive	10f. Zip Code 20850	10g.	Citizen of What Cou	
336	be filed within 72 hours after death with the Maryland ital Hygiene. od other than "natural", or Items 23e or 28e-f ehow event, the Medical Examination intellies inclified at	by Funera	Armed Forces? 1 ☐ Never Married 2 ☑ Married	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Pican, etc.)	14. Race - Americ Black, White,	etc.
21215-0036	within 72 hou ene. than "natura he Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	odent's Usual Occupation s kind of work done during most of work DO NOT use retired) mander	ing	5 Power	,
land 2	should be filed within od Mental Hygiene. marked other than 'matic event, the Mental Matic event, the Mental Menta	To Be Co	17. Father's Name (First, Middle, Last) Ona Wyatt	18. Mother's Nam	e (First, Middle, Maid le Wyatt	den Sumame)	3quadron
Maryland	alith ar		19a. Informant's Name/Relationship (Type, Print) Patricia Wyatt Juhrs-Daugh ter-	ng Address (Street and Number or Rur 15708-Anamosa	al Route Number, Ci Dr., Roc	ty or Town, State, Zip KVille, Mo	d.20850
Baltimore,	permit. Pages 1 au Department of Hea Important: if item any injury or othe		20a. Method of Disposition 1	osition (Name of matory or other place) itan Crematory-	Date 200 -5/21/05-	. Location - City or To -Alexand:	own, State ria, Va.
Balt	permit. Departimport any inj		21. Signature of Funeral Servi Loensee  23. 23a. Part 1. Enter the disease, or complications that aused the death. Do not en	2. Name and Address of Facility Hysong Co., In 6510-16th St.	nc.	shDC	
	Pnysician /Medical	1	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	er the mode of dying, such as cardiac	of respiratory arrest,		Approximate Interval Between Onset and Death
	Examiner	7.	Due to (or as a consequence of):	monia			
58760,	icate be executed physician and s the burial-transit	edical Examiner	cause Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  C				
P.O. Box 68	The law requires that the death certificat ate has been signed by the attending phy age 2 should be detached for use as the	Physician/Medi		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver	ery Day Year
	w requires that I been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the u Dehydration, renal Uncontrolled diabetes, 57	nderlying cause given in Part I.	23e. Did tobaco	co use contribute to the	he cause of death?
Vital Records,	The law require has been bage 2 shou	Completed	Uncontrolled diabetes, 57	roke	24a. Was an autopsy performed	prior to co death?	ppsy findings available impletion of cause of
	nysician: The la nis certificate ha i director, page?	o Be	25. Was case referred to medical examiner?  1 □ Yes 2 ☑ No  Hospital: 1 ☑ npatient 2 □ ER/Outpatien	Othor	h (Check only one)	6 □Other (Specif	
Division of	ing Pl	atlon; T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury		28d. Describe how in		,
Divis	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, ste building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St	t and Number or Rura tate)	I Route Number,
	he Hosp in 24 hou he Fune pletely fil	Medical	29a. Certifier  (Check only one)  1 ★ Certifying Physician: To the best of my knowledge, dealt contained to the basis of examination and/or in and manner stated.	n occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause red at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
)	To the within 2 To the complete	2	29b. Signature and title of certifier	29c. License number	į.	Date signed (Month,  Mcy 18	
2	(3)		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) B47518 eburur Piko	#407,	Rocker	10 20852
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 2 3 2005  32 Registrar's Signature	all .			

			For State Registrar		State of	Marylan		artmen rtificate					giene Reg. No.	005	18870
	Dhusisi		1. Decedent's Name (First, Mid-	ile, Last)					-		2	Date of De	ath Day	Yee	3. Time of Death
	Physici /Medi		Kenneth		F.		Ward					May	17,	2005	
	Examir		4a. Facility Name (If not instituti	on, give s	treet and numb	er)		4b. City,	Town, or	Location of	of Death		4c.	County of De	ath
			116 Lillian	Lane						Sprin				iontgon	
	Funeral		5. Social Security Number	6. Sex	M 2□F 7.	Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under Hours	Min.	Date of Bir (Month, Da	th y, Year)	9. B	irthplace (State or Foreign Country)
	Director		024-12-9968	1 123	201	80	) Yrs.	111			A	ug. 13	, 19	924 Ma	ssachusetts
	and *		Usual Residence of Decedent  10a. State 10b. Count	v		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	lanyli eho	ក													1 Yes 2 No
	28a-1	ect	Maryland  10e. Street and Number	Mon	tgomery		Si	lver		ng			10- 03		
	with te	급		-				10f. Zip					iog. Cili	zen of What (	,
	72 hours after death with the Maryland naturel', or iteme 23a or 28a-1 ehow dissa Examiner must be natified at	Funeral Director	116 Lillian		O Was Dasads	at Cuaria II	6 110 1	Man Daniel	209		-:-0./0				States
	item per de	'n	11. Marital Status  1 □ Never Married 2 ☑ Ma	1	2. Was Decede Armed Force 1 ☑ Yes 2	es?	.5.	f Yes, spec	ent of His ify Cubar	panic Ori , Mexicar	gin? (Speci i, Puerto Ri	y Yes or No an, etc.)		Black, Wh	nerican Indian, nite, etc.
36	i', or	by F	3 ☐ Widowed 4 ☐ Divorce		If Yes, Give Year or Date	1942-	-52	1□Yes a	≥⊠ No	Specify:				Specify:	White
5-0036	tura stura	ed	15. Decede				16a, Dece	dent's Usua	I Occupa	tion			16b Ki	nd of Busines	s/Industry
15	in 72	Completed	(Specify only high	est grade			(Give	kind of wor DO NOT us	k done di e retired)	uring mos	t of working				,
2121	iene iene	E	Elementary/Secondary (0-12)		College (1-4 5+	or 5+)	Eng	jineer	ing				Fe	deral	Government
ğ	Hyg othe	Bec	17. Father's Name (First, Middle	, Last)						18. Mothe	r's Name (I	irst, Middle,	Maiden	Sumame)	
au	id be enta ked c ev	To B	William R. W	ard						R	uth G	race T	horn	rose	
Maryland	shound M	-	19a. Informant's Name/Relation	ship (Typ	e, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	er or Rural F	loute Numbe	er, City o	r Town, State	, Zip Code)
Ž	lith a		Helen Ann Wa	rd/	Wife										land 20904
ō,	Head of the		20a. Method of Disposition				Place of Dispo	sition (Nan	ne of		Dat	9			or Town, State
no	ages ant of it: If i		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		moval from Sta	110	emetery, crer e of Hea			·	May	1 1			
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If item 27 is marked other then "natural", or iteme 23a or 28a-1 ehow eny injury or other traumatic event, the Medical Examinar must be notified at ances.		21. Signature of Funeral Service		A -	Gat					200				ing, Maryland
Ba	Dep impo		23a. Part 1. Enter the disease,	9	Cole		50	0 Uni	vers	ity	Elvd,	W, Si	lver	e Inc.	g, MD 20901
8760,	Physician /Medical Examiner physician and physician and physician and the priral-transit	Ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause in the	b. c.	Due to (or	hosis as a conseq as a conseq as a conseq	uence of):	er							
.O. Box 6	The law requires that the death certificate be execuled tie has been signed by the attending physiclan and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23	Sc. If yes, outcome 1 Live birth 4 Pregnan 9 Unknown	n 2 ∏ Feta t at time of d	Ideath 3	Ectopic pre					2	3d. Date of d Month	elivery Day Year
Records, P.	puires tha n signed uld be det	Completed by P	Part II. Other significant condit Waldenstrom's												to the cause of death?  Probably 4 Unknown
00	w requir been si should	ete										24a. Was	an	24b Were a	autopsy findings available
Re	he ta e has	E C											rmed?	prior to death?	completion of cause of
B	(d car	Ö .	25. Was case referred to medic									1 Yes		1 ☐ Ye	s 2 No
$\equiv$	Physician: The law this certificate has t ral director, page 2 s	00	examiner?  1 Yes 2K No		ospital:		5010		Othou			check only o			
of Vital	Phys rat di	5.	27. Manner of Death	-	28a. Date of I		ER/Outpatien 28b. Time of		^	4 1140	_	5 🔼 Resid		Other (Sp	ecify)
Division	Attending F r death. ector: After by the funer	Certification;	1 ₺ Natural 5 □ Pend	ng igation	(Month,	Day Year)	Injury	м	Sc. Injury Work?	?` es 2 □ 1				00001100	
S	i or Attendi after death. Director: A	lica	3 ☐ Suicide 6 ☐ Could	not be	28e. Place of	Injury - At ho	me farm str					Location /S	Street and	1 Number or 6	Rural Route Number,
<u>S</u>	i or A after Direction by	ert	4 Homicide deter	mined	building	etc. (Specify	y)	soi, laciory,	Onice		20.	City or Tou	m, State)	, , , , , , , , , , , , , , , , , , , ,	lurar riodio riarilber,
	pital ours eral filled		29a. Certifier 1 Certif	nd Bhyo	cian Tathaha	et of my kno	wledge death		4 45 4		4-1	dua ta tha			
	Hos Fun Fun	lica	(Check only 2 Medical one)	Eyamin	cian: To the beer: On the basi	s of examina	tion and/or inv	estigation,	in my opi	nion, deal	d place, and th occurred	at the time,	date and	and manner a place, and du	is stated. le to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29b. Signature and title of certif	1	and hanner	Jiaiou.		290	License	number			29d Date	a sinned (Mor	nth, Day, Year)
	F 3 F 8			IV	/ //			200.	D16					y 17,	
	2441			4										<i>,</i> = · <i>,</i>	
	,		30. Name and address of perso Joel Goozh,		1		1 23a) (Турв. 1 .edge D		#40	1, Be	ethesd	la, Ma	ryla	nd	
	Sta Registr	_	31. Date filed (Month, Day, Yea MAY 1 9	·)			ture			-					
	1.091011	2	11111 1 7 9	LUU.	MARIEN	المار مري	100								

			For State Ragistrar AVEND#29dpc				artment of F		ind Mei	, ,			
	Physici /Medic		1. Decedent's Name (First, Middle,		WAL	SH	incate or	Douin	2.	Date of Deat	i Day Y	05	3. Time of Death/
	Examin		4a. Facility Name (If not institution, WAS UTWA TO			3T	4b. City, Town, o	1A PI	tock	mis	4c. County of MON	Death TC(	onery
	Funeral Director		5. Social Security Number 577-64-9995  Usual Residence of Decedent	6. Sex 1	7. Age (In yrs. 57	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. Ma	Date of Birth (Month, Day, arch 2!	<sup>Year)</sup> 1948	Count	ace (State or Foreign ry) hington, D
	n the Maryland r 28s-1 show incilled at	ō	10a. State 10b. County  Maryland	Montgome		y, Town or Lo						10	od. Inside City Limits  1 ☐ Yes 2X No
	with the Maryland is or 28e-1 show	Director	10e. Street and Number 9109 Walden R		ery	SIIV	er Spring 10f. Zip Code 2090			1	0g. Citizen of Wha	at Count	ry?
ဖွ	ours after death with el', or Items 23a or	Funeral	11. Marital Status 1 □ Never Married 2 점 Marrie	12. Was Dec	2 🔼 No	ļ	Was Decedent of H If Yes, specify Cubs 1 Yes 2 No	lispanic Orig	jin? (Specif , Puerto Ric	y Yes or No- an, etc.)	14. Race - Black,	America White, e	tc.
21215-0036	은 결제	eted by	3 Widowed 4 Divorced  15. Decedent' (Specify only highesi	Year or D	Dates:	16a. Dece	dent's Usual Occup	ation during most	of working		Specify: 1		
12121	s 1 and 2 should be filed within 72 if Health and Mental Hygiene. item 27 le marked other then "ne other treumetic event, If e Media	Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)		nior Vice	Presi		Siret Middle A	Banking		
Maryland	2 should be f and Mental H le marked ot eumetic ever	To Be	17. Father's Name (First, Middle, Last)  Edward J. Walsh  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod										
	1 and 2 sl Health and sm 27 le n ther treur		Mary L. Walsh/ 20a, Method of Disposition		20b P	9109	Walden R sition (Name of			Sprin		Land	20901
altimore,	Page ment c		1 □XBurial 2 □ Cremation '4 □ Donation 5 □ Other (Sp	ecify)	State c	emetery, cre e of Hea	natory or other place even Cemete:	ry	May 20 2005	0, 5 S	ilver Sp	ring	, Maryland
Ba	permit. Departr Import eny Inj		21. Signature of Juneral Service L	J. Col	e	50		sity E	Blvd,	W, Sil	ver Spri	ing,	MD 20901
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a.	caused the death each line.	TC No not en	= 1	_		PHTH			Approximate Interval Between Onset and Death
4	/Medical Examiner	er		b. EN	(or as a consequence of the cons	SHE	RENI	te	DIS	eas	E		
bone/B.Mechnes 18760,	be executed sician and burial-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consequ							-	·
abone/B 68760,	phy:	dlcal	Ŋ.	d									
(δ. β <sub>Α</sub> . <b>Box</b>	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live t	itcome of pregna birth 2 Tetal nant at time of do nown	I death 3	Ectopic pregnancy Other (specify)		. 1		23d. Date of Month		y Day Year
, ,	quires that the de on signed by the a uld be detached f	by	Part II. Othar significant condition	s contributing to d	death but not resu	ulting in the u	nderlying cause giv	en in Part I.			pacco use contribu		100
Box 29D		Completed								24a. Was ar autops perform	y prio ged? dea	r to com th?	sy findings available pletion of cause of
redo i	S 0	To Be	25. Was case reterred to medical examiner?	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DOA Oth	00		5 Reside	e) nce 6 Other	(Specify)	
Exbal Ok to Ameuo Box 290 per Division of Vital Records,	Jing J. After fune	Medical Certification;	27. Manner of Death    Natural   5   Pending investig   3   Suicide   4   Homicide   Geterming	ot be 28e. Place	of Injury of Day Year) e of Injury - At ho ling, etc. (Specify	28b. Time o Injury	Wor	yat k? Yes 2 □ N	10		reet and Number of State)	or Rural	Route Number,
(esbal	To the Hospitel or Attend within 24 hours after death To the Funere! Director: completely filled in by the	dical Ce	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									ted. the cause(s)	
		Me	29b. Signature and title of certifier		DHUCT	111	29c. Licens		120		9d. Date signed (A		ay, Year)
	12		30. Name and address of person v			23a) (Type,	Print) 760	0 C/	Ann	0101	95/17/0 Aveni M5 5	LED	12
	Sta Registr		31. Date filed (Month, Day, Year)  MAY 1 9 2	Meron 1005	Registrar's Signa	ture	li)	Tript	pical	My	11(9)	-0-1	10

		1 - For State Registrar	State of	Maryland			nt of H te of L			lental Hy	giene Reg. No	2000		8873
Physic		Decedent's Name (First, Middle, L.	ast)	500						2. Date of De Month	Day	le Year	- 1	Time of Death 2 ひろ (¬)M
/Med Exami		4a. Fecility Name (If not institution, gi	ve street and numb	per)		4b. City	Town, or	Location of	of Death			County of Dea	ith	=1
Funera Director		579-18-1639	Sex 7 1 □ M 2 🙀 F	Age (In yrs. la		If Und Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da )1/21/1	A.fra	9.1	rthplace ( ountry)	State or Foreign
Maryland f ahow	or	Usual Residence of Decedent  10a. State 10b. County  MARYLAND MOI	TGOMERY	10c. City	, Town or Lo		OCKVI	TIE				, , , , , , , , , , , , , , , , , , ,		side City Limits
n with the 3s or 28s	i Director	10e. Street and Number 14627 POMMEL DRIV					p Code	2085	50		10g. Citi	zen of What C	ountry?	
I.Z. 13-0030 within 72 hours after death with the Maryland sne. then "natural" or frama 23e or 28e-f ahow he Maryland Extraitment be recitified at	by Funerai	11. Maritat Status  1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Deced Armed Forc 1 Tes 2 If Yes, Give Year or Dat	es? ☑No		fYes, sp	edent of Hi ecify Cuba 25 No	spanic Ori	gin? (Spe	city Yes or No Rican, etc.)	1	14. Race - Am Black, Whi Specify: WH	erican Ind te, etc.	dian,
Z I Z I D-UUSO at od within 72 hours af giene. "natural", or then "natural", or the Model Extra	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4	lor 5+)	life.	kind of w	ual Occupa ork done d use retired,	luring mos	t of workin	ng	16b. Kir	nd of Business	/Industry	
be file	To Be C	17. Father's Name (First, Middle, Las MORRIS CHUPRECK	<i>t)</i>			WILLIA		18. Mothe		(First, Middle,	Maiden		/1 <u>F.L</u>	
nd 2 alth a 27 ts		19a. Informant's Name/Relationship JEANNE EVANS/DAUG								Route Number			Zip Code 208	
Definition of the properties o		20a. Method of Disposition  1  Burial 2 □ Cremation 3  1 □ Other (Special Contents)		ate Ce	ace of Dispo metery, cren XI ISR	natory or	other place			2005		cation - City or		
permit. Pages 1 Department of H Important: if ite any injury or ot once.		21. Signature of Funeral Service Lice	Kudew	ra	DÃ <sup>2</sup>	NZAN 170	SKŸ₫res ROCKV	oldbe ille	RG M PIKE	EMORIA	CHA	APELS,	INC.	
Physician /Medical Examiner		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underpling Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or	as a consequence as a c	ence of):	440		S-56.a			1001,		Inter	oximate val Between st and Death
that the death certificate be executed ed by the attending physician and detached for use as the buriat-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	d	ome of pregnan h 2 □ Fetal nt at time of de	ncy death 3	Ectopic p	pregnancy				2	23d. Date of de Month	livery Day	Year
8 6 g	b	Part II. Other significant conditions	contributing to dea	th but not resul	Iting in the ur	nderlying	cause give	n in Part I.	-			se contribute to		se of death?
sician: The law requir certificate has been si	Completed								·	24a. Was autop perfo		prior to death?	utopsy fin completic	idings available on of cause of
Phys rathis	To Be	25. Was case referred to medical examiner?  1  Yes 25No  27. Manner of Death  15Natural 5 Pending	28a. Date of (Month,	oatient 2 E Injury Day Year)	ER/Outpatien 28b. Time of Injury		28c. Injury Work	at	rsing Hom	(Check only one 5 Residuel Res	dence 6		cify)	
or Attending after death. Director: After d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not lead determined	28e. Place of	Injury - At hor , etc. (Specify)	ne, farm, str	M eet, facto		′es 2 □ l		8f. Location (5 City or Tou	Street and vn, State)	l Number or R	ural Route	e Number,
To the Hospital or Attan within 24 hours after deal To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one)  12 Certifying P 2 Medicat Exa	hysician: To the b miner: On the bas and manne	is of examination	vledge, death on and/or inv	occurred estigation	at the tim	e, date and inion, deat	d place, a	nd due to the o	cause(s)	and manner as place, and due	s stated.	ause(s)
To the I within 2.	W	29b. Signature and title of certifier	7/20/0	Con.			COS		\		29d. Date	signed (Mont	h, Day, Y	(ear)
		30. Name and address of person who	completed cause	of death (Item	23а) (Туре,				3	~ 5}	Ro	Wille	1 WI	
St Regist	ate trar	31. Date filed (Month, Day, Year)	2005	istrar's Signatu	". Ap									

State of Maryland / Department of Health and Mental Hygiene For Stata Registra Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Yeer Physician CELIA MAY 18, 2005 WEINSTEIN 10:55 P<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** MARINER HEALTH CARE BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🕅 F Yrs. 216-40-8901 96 04/09/1909 Director MARYLAND Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-1 show other treumatic event, the Medical Examinativing by notified at 1 ☐ Yes 2 No Directo MARYLAND MONTGOMERY **BETHESDA** 10g. Citizen of What Country? 10f. Zip Code ō 5721 GROSVENOR LANE 20814 permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e any injury or other treumatic event, the Medical Example 1 until once. U.S.A. Completed by Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOSEPH SAMUELS IDA SEIDMAN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALAN WEINSTEIN/SON 5225 POOKS HILL ROAD #124SOUTH, BETHESDA, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State A □ Donation 5 □ Other (Specify) LEBANON CEMETERY 05/22/2005 ADELPHI, MARYLAND 21. Signature of Funeral Service Licensee 22 Name and Address of Faculty
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** FAILURE TO THRIVE disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner DEMENTIA Sequentially list conditions, Due to (or as a consequence or, Examine cause. Enter Underlying Cause (Disease or injury use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tra Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ed by the a detached f 9 Unknown cate has been signed by , page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes **3**√□ No Hospitel or Attending Physicien: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 41 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a To the Funeral ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 2 40051280 MAY 19, 2005 30. Name and address of person who completed cause of death (item 23a) (Type, Print)
DR. ANUSHIVAVAN DADGAR, 9715 MEDICAL CENTER DRIVE, SUITE 201, ROCKVILLE, MD 20850 31. Date filed (Month, Day, Year) Registrar's Signature State 2005 Registrar

		1 - Stata Registrer			artment of F rtificate of		,	Reg. No.	005	18871
Physic /Medi		1. Decedent's Name (First, Middle, La	Doris R.	Wilhe			2. Date of De Month May	27,	Year 2005	3. Time of Death 12:15 A
Exami	ner	4a. Facility Name (If not institution, gi Stella Mari			Timoni		γω.		ounty of Death	
Funeral Director		5. Social Security Number 180-22-4161  Usual Residence of Decedent	Sex 7. Age (In yn 75	s. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birt Month Da	30°	9. Birthp Cour Penn	lace (State or Foreig stry) Sylvania
R-f show	ctor	10a. State 10b. County PA York		Dover			l Sie		1	0d. Inside City Limits
23e or 28	Funeral Director	10e. Street and Number 6465 Dupont Ave	enue		10f. Zip Code	<b>1731</b> 5		- "	of What Cour	itry?
penint. Tages I and 2 should be new within 2 hours are bean with the warpan. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inportent: If the Mr 27 is marked other than "natural", or fems 23e or 28a-f show eny injury or other traumatic event, the Medical Examinal must be notilized at once.	b	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2X No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		Race - Americ Black, White, pecify: Wh	
n "natur Medical	To Be Completed	15. Decedent's E (Specify only highest gi	ducation rade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	ting		of Business/Inc	
Hygiene other tha	e Com	17. Father's Name (First, Middle, Las		La	undry So	rter 18. Mother's Nam	e (First, Middle,			Cleaner
Mental arked atic ev	To B	Harry A. Gla				l	sie C.			
uith and 27 Is m r traum		19a. Informant's Name/Relationship Charles F. W			-	and Number or Rur . Ave.,		-	own, State, Zip 17315	
nysician Medical xaminer	her	23a. Part1. Enter the disease, or cor shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	a. CURONARY  Due to (or as a consi	ARTERY		ng, such as cardiac	or respiratory ar	1651,		Approximate Interval Between Onset and Death
ate be executed hysician and he burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a const							
y the attending physician and ched for use as the burial-transit	cal	that initiated events	c	equence of): gnancy etal death 3 [	□Ectopic pregnanc □ Other (specify) _	у		23d	f. Date of delive Month	ory Day Year
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as been signed by the attending phys. 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Xes	c	equence of): gnancy stal death 3 [ f death 5 [	Other (specify)		1 🗆 1	obacco use Yes 2 1 N an 2 osy rmed?	Month  contribute to the state of the state	Day Year ne cause of death? ably 4 \(\overline{\pi}\) Unknow psy findings available mpletion of cause of
iaw requires that the beam centricate as been signed by the attending phys 2 should be detached for use as the	To Be Completed by Physician/Medical	Lause (Disease or Injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	C. Due to (or as a consider of the contributing to death but not recontributing to death but n	equence of):  gnancy etal death 3 [ f death 5 [ esulting in the u  ER/Outpatier 28b. Time o Injury	Other (specify) _  Inderlying cause grant 3 \( \text{DOA} \)  Other (specify) _  Other (s	ven in Part I.  26. Place of Deat	24a. Was autor period 1 Yes th (Check only of the Check on the C	obacco use  Yes 2 1 N an 2 ssy rmed? 2 No one)  dence 6 No owinjury o	Month  contribute to the second of the secon	Day Year  ne cause of death?  abiy 4 \( \frac{\text{V}}{\text{Unknown}}\)  psy findings available impletion of cause of 2 \( \text{No} \)
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interraining Prysicient: The law requires that the uean betrificate death. stor: After this certificate has been signed by the attending phys the funeral director, page 2 should be detached for use as the	To Be Completed by Physician/Medical	Lause (Disease or Injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1   Yes 2   No  27. Manner of Death 1   Natural   5   Pending investigate   1   Yes   1   1   1   1   1   1   1   1   1	C. Due to (or as a consider of the contributing to death but not recontributing to death but n	equence of):  gnancy stal death 3 [ f death 5 [ esulting in the u  BEP/Outpatier 28b. Time of Injury chome, farm, sta	other (specify) inderlying cause gr  nt 3 \( \text{DOA} \)  other 28c. Inju Wo M 1 \( \text{Treet, factory, office} \)	zen in Part I.  26. Place of Deather: 4 □ Nursing Hory at rk?  Yes 2 □ No  me, date and place, opinion, death occur	24a. Was autop performent of the comment of the com	obacco use  Yes 2 1 No an an ssy rmed? 2 1 No dence 6 1 No own injury of  Street and No vn, State)  cause(s) an date and pla	Month  contribute to the contribute to the contribute to the contribute to the prior to contribute to contribute to contribute to contribute to contribute to contribute to the contribute to	Day Year  ne cause of death?  nably 4 \( \frac{\text{\text{W}}}{\text{Unknown}} \)  psy findings available impletion of cause of 2 \( \text{No} \)  HOSPICI  ### HOSPICI  ##################################

DHMH 17 Rev 1/2001

MAY 27, 2005 12:15 a.m.

DORIS WILHELM

			1 - For State Registrar	State o	f Mary	land / Depa	artment of tificate of	Health	and M	•		2005	18875
	Physici	an	1. Decedent's Name (First, Middle ROWLAND ED)		TTE.	JR.				2. Date of D Month	Day	Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City, Town,	or Location	of Death	May	31 4c. (	2005 County of Death	
			55 Little Cre				_	boow	0.11			Harfor	
	Funeral Director		219-10-5933	6. Səx ▼ M 2□ F	7. Age (In 80	yrs. last birthday) Yrs.	If Under 1 Year Months Days		r 24 Hrs. Min.	8. Date of Bi (Month, D 2/1/19	irth Pay, Year) 1925	9. Birth Con Mary	nplace (State or Foreign untry) land
	yland now		Usual Residence of Decedent  10a. State 10b. County		100	c. City, Town or Lo	cation						10d. Inside City Limits
	Be-fsh	ctor	MD Harfo	ord		Edgewo							1 ☐ Yes 2 XXNo
	death with the Maryland ms 23e or 28e-f show r must be nuditied at	Dire	10e. Street and Number 55 Little Cree	ek Lane			10f. Zip Code 2104	.0				en of What Cor JSA	untry?
	ams 2:	nera	11. Marital Status	12. Was Dec Armed Fo	edent Ever	in U.S. 13.1	Was Decedent of f Yes, specify Cul		rigin? (Spe	cify Yes or N Rican, etc.)		4. Race - Amer Black, White	
38 6	pergit. Pagas 1 and 2 should ba tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. mportant: if item 27 is marked other than "naturel", or itams 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be muitibut at 2008.	Completed by Funeral Director	1 Never Married 2 Marri 3 Widowed 4 Divorced	ed 1 XYes	2 No		1□Yes <b>X</b> □No			, ,		Specify:USA	
5-00	72 hou	eted	15. Decedent (Specify only highes	s Education		16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	pation during mo	st of worki	ng	16b. Kin	d of Business/I	ndustry
1212	within ene. than *	dmo	Elementary/Secondary (0-12)	College (	-			ed)		Construction			
nd 2	a filed al Hygi I other vent, I	To Be Co	7 Foreman  T. Father's Name (First, Middle, Last) 18. Mother's Na								e, Maiden S		201011
( <del>\</del> \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	d Ment d Ment narkac natic e		17. Father's Name (First, Middle, Last) ROwland E. White  18. Mother's Name Drusil									Tour State 7	in Code)
Na Ba	and 2 sl ealth and n 27 Is r		19a. Informant's Name/Relationship (Type, Print)  Mary Jane White/Wife  19b. Mailing Address (Street and Number or Rur  55 Little Creek Lane,								-		
D.C.	gas 1 a of Hec If item or othe		20a. Method of Disposition 1 □ Burial 2 🌣 Cremation	3 □Removal from	State		natory or other pla			ate	20c. Loc	cation - City or	Town, State
3#	it. Pagas intment of I intant: If it injury or o		* 4 □Donation 5 □ Other (Sp. 21. Signature of Funeral Service)	ecity)		Evans Fagi	e Cremator  . Name and Addr		5/31/2	2005	Leola	a, PA	
五點	permi Depar Impor any ir		Velley P.	Toule	do	1				c.,600 M	<b>a</b> in St	,Delta,	PA 17314
	£e:		23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on c	caesed the each line.	death. Do not ent	er the mode of dy	ring, such a	s cardiac o	r respiratory a	arrest,		Approximate Interval Between Onset and Death
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- 8	Examiner												
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ó	ate be exacuted hysician and the burial-transit		that initiated events c.  resulting in death) Last  Due to (or as a consequence of):										
8760,	cate be physici the bu	dlcal	d										
9 xo	Jeath certificate b attending physion	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou			75				2:	3d. Date of deli	very
P.O. Box 68	Attending Physicien: The law requires that the death certifica is death. sr death. ector: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the second of the funeral director.	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nant at time		Ectopic pregnand Other (specify)					Month	Day Year
		by Ph	Part II. Other significant condition	ns contributing to c	leath but no	ot resulting in the u	nderlying cause g	iven in Part	I.	23e. Did	tobacco us	se contribute to	the cause of death?
ord	w requires been sign should be	eted								4	Yes 2		obably 4 Unknown
Rec	he law e has b ige 2 s	Completed									opsy ormed?	prior to c death?	topsy findings available ompletion of cause of
ital	ilcien: Th certificate rector, pag	Be Co	25. Was case referred to medical examiner?					26. Plac	e of Death	1 ☐ Yes (Check only	2 No one)	1 🗆 Yes	2)X No
of V	ding Physicien: The In. After this certificate he funeral director, page	ပ္	1 Yes 2 No			2 ER/Outpatier	IL 3 DOA			ne 5 Res		Other (Spec	ify)
on	nding Phys tth. r: After this e funeral di	atlon	1 Natural 5 Pending		of Injury oth, Day Yea	ar) Injury	W	ork? □Yes 2□		.od. Describe	now injury	occurred	
Division of Vital Records,	or Attendi ifter death. Director: A in by the fu	Certification;	3 Suicide 4 Homicide  3 Suicide 4 Homicide  4 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural City or Town, State)							ral Route Number,			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ical Ce	29a. Certifier (Check only (Ch										
	o the hithin 2 of the formplet	Medical	one) and manner stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month,							, Day, Year)			
	- > - 0		) of Sun	araela	en	M.D	DA	553	0		05.	-31-0	1005
	. 8		30. Name and address of person of SIVA SAILA	who completed cau	se of death	(Item 23a) (Type, ATWOOD	Print) ROAD	SUITE	200	, BE	LAIR	MD 2	1014
	Sta Registr		31. Date filed (Month, Day, Year)  JUN 0		gistrar's S	Signature	net !		,				/

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death May 29, Year **Physician** 2005 Fannie May Williams 6:15 PMM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Vindobona Nursing Home If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Month, Day, May 2, 9. Birthplace (State or Foreign Country) Mary Land 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 217-32-5195 1 ☐ M 2 💢 F 98 1907 Yrs. Director Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at Jefferson Maryland Frederick 1 Yes 2 No Director 10f. Zip Code 21755 10g. Citizen of What Country? 10e. Street and Number 4319-D Lander Road Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. e filed within 72 hours after de al Hygiene. al Hygiene. other than "natural", or item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be es 1 and 2 should be fi of Health and Mental H I item 27 Is marked ot Fannie Matilda Moxley A.I. Benjamin Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Carl Jane Wiles, daughter 4319-D Lander Road, Jefferson, MD 21755 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

Disposition

Removal from State 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. Mount Olivet Cemetery June 1, 2005 Frederick, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) <sup>2</sup>K୯୯୩୯୨<sup>A</sup>ଅମଫ Bଅଟିord PA Funeral Home 106 East Church St., Frederick, MD 21. Signature of Furnical Souvice Lices MOO255 21701 Approximate Interval Between Opset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause / n each line. PNEUMONIA Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ CORONARY METERY DITEMSE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 20 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury Natural 5 Pending 1 🗌 Yes 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier cal (Check only one) 29c. License number 0 16675 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie M.D. 2005 death (Item 23a) (Type, Print)

RUNSWICK 30. Name and address of person who completed cause of MUGMER 31. Date filed (Month, Day, Year) State JUN 0 6 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 11:03 P M Vada Ellen Wolfe May 2005 30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Baltimore Towson If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Feb. 6, Funeral 6. Sex 9. Birthplace (State or Foreign 1□ M 2**X**F 214-20-0322 83 Director Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked othar than "natural", or Items 23a or 28a-1 show traumatic evant, the Medical Examinar must be notified at MD 1 ☐ Yes 2X No Director Baltimore Freeland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1515 Freeland Rd. 21053 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Post Office Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H Robert Lee Beamer Lila A. Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other trau Reginald E. Wolfe/Husband 1515 Freeland Rd., Freeland, MD 21053 20b. Place of Disposition (Name of cometery, crematory or other place)
Mt. Zion United
Methodist Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State June 4, 1 Burial 2 Cremation 3 Removal from State Freeland, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 2005 21. Signature of Fune of 5 rvice Licens to 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. auxs. Vas en 24 Second St., New Freedom, PA 17349 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician weeks /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ti brillation Loumadin 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed COVONAVY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 2 No 1 Tyes 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; Hospital or Attending 1 Natural 2 Accident Injury 5 Pending after death. investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To tha Funaral Dirac 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 1)25205 wo npleted cause of death (Item 23a) (Type, Print) 30. Name and address of person N. Charles St. Balto. and 21204 D Anthony GBMC 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3, 2005<sup>ear</sup> **Physician** SR. JUNE ANDERSON MIAYME 4:56A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner UNIVERSITY HOSPITAL BALTIMORE NIA 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 05 · 0 ( 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 21848.2088 1 M M 2 □ F Yrs. Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumetic event, the Mudical Evaniner must be notified at Completed by Funeral Director BALTIMORE 1 XYes 2 □ No MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 513 WYETH STREET USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ent: If item 27 is marked other then "naturel", or Itel 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPING SUPERVISOR NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be PURCELL ANDERSON OLIVIA SLADE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 i MIFE 508 SANFORD PLACE BALTO. ANDERSON VIRGINIA Mn 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State ö permit. Page Department of Importent: If any injury or once. MT. ZION <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 06.10.05 BALTO. MD VAUGHN C. GREENE FUNERAL SERVICE 21. Signature of Funeral Service Licensee a 5151 BAUTO NATU PIKE, BAUTO MO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear-failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Physiclan/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): attending physician use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ģ Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown filled in by the funeral director, page 2 should Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Certification; To 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending after death. 1 Yes 2 No investigation 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME JUNE 3, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA RUBIO MD. 111 Penn Street Baltimore, Maryland 21201 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

			1 - For Stata Registrer	ate of Maryla		artment of I		nd Mental Hy	giene	Eng	18880
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De	eath Day	y Year	3. Time of Death
	/Medic		Judith Miller A					May 31		005	4:00 a M
	Examir	er	4a. Facility Name (If not institution, give street			4b. City, Town, o		Death	4c.	County of Death	
-			Randolph Hills Nur  5. Social Security Number 6. Sex		s. last birthday)	Wheato		Hrs. 8. Date of Bi	-the	Montgo	
	Funeral Director		523-43-3168		Yrs.	Months Days		Min. (Month, Da	ay, Year)		place (State or Foreign untry)
			Usual Residence of Decedent	22 00				Oct. 3	<u>10 1</u>	924 K	entucky
	nylan ihow	_	10a. State 10b. County	10c. 0	City, Town or Lo	cation					10d. Inside City Limits
	Ba-f s	cto	MD Montgome	ry	Silve	r Spring	**				1 XYes 2 No
	or 2	Director	10e. Street and Number			10f. Zip Code			10g. Citi	izen of What Cou	intry?
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	item item	Funeral	A	/as Decedent Ever in med Forces?	0.5.	res, specify Cub	an, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	)-	<ol> <li>Race - Amer Black, White</li> </ol>	
336	urs af	by	3√ Widowed 4 Divorced Y	☐ Yes 2. No Yes, Give X ear or Dates:		I□Yes 2√2 No	Specify:			Specify:	hite
Ö	within 72 hours after death with the Maryland jiene. rthen "neturel", or items 23a or 28a-f show the Madical Examinar must be notified at	Completed	15. Decedent's Education		16a. Deced	lent's Usual Occu	oation		16b. K	ind of Business/li	ndustry
21	within 7 ene. then "r	nple.	(Specify only highest grade com Elementary/Secondary (0-12)	ollege (1-4or 5+)	life. L	kind of work done OO NOT use retire	d) most of	r working		orm ham	
7	filed with Hygiene. other ther	S	8		Но	memaker				own home	
and But	be de la	Be	17. Father's Name (First, Middle, Last)				18. Mother's Jess	Name (First, Middle		Sumame)	
3	should be ind Mental marked o umatic eve	ဥ	unavailable  19a. Informant's Name/Relationship (Type, P	h-f-al	401 14-75						
Maryland 21215-0036		h P	David Adam/Son	runij				or Rural Route Numb	-		
	1 an Heal		20a. Method of Disposition	20b	. Place of Dispo	sition (Name of natory or other pla	stree	t, Silver		Ln MD cation - City or T	20902 own. State
20			1 Burial 2 Cremation 3 Removed 4 Donation 5 Other (Specify)	rai ilolli State			1	6/3/05		iangle,	
Baltimore,	2 2 2 P		21. Signature of Funeral Service Licensee		22	National Name and Addre	ess of Facility				***
B	Depa Impo eny ir		Stally	M003	I I	Rapp Fune	ral an	d Crematio	on Se		
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused the de	ath. Do not ente	er the mode of dyi	Avenue	Silver Sindiac or respiratory a	oring trest,	3, MD 2	A G 1 A ximate Interval Between
	Prrysician	i ny	Immediate Cause (Final disease or condition								Onset and Death
	/Medical		resulting in death)	Due to (or as a conse		y Diseas				-	
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	and and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to /or an a cons	naugang of):						
8760,	be executed sician and burial-transit	E	, , , , , , , , , , , , , , , , , , ,	Due to (or as a conse	equence or):						
387	ate Pe Sy	dical	d								
9 xc	death certifica attending ph if for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If	yes, outcome of preg	nancy					23d. Date of deliv	ien.
Вох	death atter	clar	in the past 12 months?	Live birth 2 Fe		Ectopic pregnanc Other (specify) _	<i>Y</i>			Month	Day Year
O.	that the d ed by the detached	hysi	9 □ Unknown 9	Unknown							
S, P		by P	Part II. Other significant conditions contribu	ling to death but not re	esulting in the ur	nderlying cause giv	en in Part I.	23e. Did 1	obacco u	se contribute to	the cause of death?
rd	w requires been sign should be		Diabetes Melli	tus Type I	Ι			1 🗆	Yes 2[	□No 3□Pro	bably 4 Unknown
of Vital Record	law as b	ompleted	Essential Hype	rtension				24a. Was		24b. Were auto	opsy findings available ompletion of cause of
Æ	The ate h page	Com	• •					— auto perfo	ormed?	death?	2 No
/ita	ysicien: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?				26. Place of	Death (Check only of			
£	Physicien: this certific ral director,	၉	1 ☐ Yes 2/1 No Hospit	1 □ Inpatient 2 i	☐ ER/Outpatien		44 Mursi	ng Home 5□ Resi			fy)
	ing Ifter	on:	1 Natural 5 ☐ Pending	a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui Wo	k?	28d. Describe	now injur	y occurred	
Sic	Attending ir death. ector: After by the fune	cat	2 Accident investigation	Discount of Lives A	hama farra at		Yes 2 □ No	004 1	C4		
Division	after after Direction by	ertification:	4 Homicide determined	e. Place of Injury - At building, etc. (Spec	cify)	эет, тастогу, оптсе		City or To	wn, State	a Number or Hur. )	al Route Number,
_	spita ours herel filled	O	29a. Certifier Certifying Physician	: To the best of my k	nowledge death	occurred at the ti	me date and n	lace, and due to the	cause(s)	and manner as	stated
	e Hos 24 h e Fur	edical	(Check only 2 Medical Examiner: (	On the basis of examination of manner stated.	nation and/or inv	estigation, in my	pinion, death	occurred at the time,	date and	place, and due t	o the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	2	()	29c. Licens	e number		29d. Dat	e signed (Month,	Day, Year)
	2.			1	1/11	D.	52261		5	/31/05	
,	7 1		30. Name and address of person who comple	ted cause of death (It	em 23a) (Type, I	Print)					
C	1		1517 Hugo Circle	Silver Sp	ring.M	20906	Dr.	Alan Seg	al.		
	Sta		31. Date filed (Month, Day, Year) 2005	Silver Sp.	ature 2004	(4)					
	Registr	ar	JON O 1 LOSS	The same of the sa							

			For	State of Maryla		artment of Health and rtificate of Death		ene 0 0 5	18881
			Decedent's Name (First, Middle, La	st)			2. Date of Death	1	3. Time of Death
	Physici		RECTHA	MAR.5	ama	15.0	Month L	Day Year	7.05 AM
}	/Medio Examir		4a. Facility Name (If not institution, giv	re street and number)	4 11 11-	4b. City, Town, or Location of Dec		4c. County of Death	1.00
1	LAGIIII		Maria Pape			Rution		Balling	-0=
-	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs	. last birthday)	If Under 1 Year If Under 24 Hi		9. Birthp	ace (State or Foreign
	Director		213-34-1857	IDM 250F	Yrs.	Months Days Hours Mi	n. (Month, Day,	Year) Coun	11.900
	D		Usual Residence of Decedent					1 10 11 11 11	74:1:10
	nylan how		10a. State 10b. County	10c. C	ity, Town or Lo	ocation		11	0d. Inside City Limits
	Ma e-1 s	to	CARLAGO BALTIG	MORE	TARKI	245			1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code	10	g. Citizen of What Coun	try?
	th wi	ai	SESE HOERNER	AVS		21234		U.S.A.	
	72 hours after death with the Maryland natural', or items 23a or 28e-1 show digal Exactions must be redified at	Funeral	11. Marital Status	12. Was Decedent Ever in I Armed Forces?	J.S. 13.	Was Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - America Black, White, 6	
9	after or Ite		1 ☐ Never Married 2 ☐ Married	1 Tes 28 No		1 ☐ Yes 2 ☑ No Specify:	Sito ricari, etc.,		HC.
8	ours	d by	3 Widowed 4 □ Divorced	Year or Dates:		TEL 165 ZUEINO Specily.		Specify: W}	211
21215-0036	72 h natu	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occupation kind of work done during most of w	rorkina 1	6b. Kind of Business/Inc	ustry
21	within iene.	ldu	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)			
	filed withi Hygiene. Ither than	Ö	10785-		Ho	WENTHER		HI HOW	2
Maryland	0 2 2 3	Be	17. Father's Name (First, Middle, Last			18. Mother's N	ame (First, Middle, M	aiden Sumame)	
yla	2 should be and Mental is marked o sumatic ave	2		KEYNO	201	Louis	5 5	C.H.HORST	
ar	es 1 and 2 should b of Health and Ment item 27 is marked r other traumatic a		19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ng Address (Street and Number or I	Rural Route Number,	City or Town, State, Zip	Code) 3 334
	and ealth n 27 er tr		BARBARA L. BA	RIJK		- HOTERS AVE	TARKVILL	2 ( IA/A) An	21 67 7
Baltimore,	of He iter		20a. Method of Disposition  15 Burial 2 Cremation 3	1		sition (Name of matory or other place)		Oc. Location - City or To	wn, State
Ĕ	permit. Pages Department of I Important: If ite any injury or of		'4 □ Donation 5 □ Other (Specif		akun	0/1	4002	Chillie 1	smalks/a
alti	permit. Departn Imports any inju		21. Signature of Funeral Service Lice	nsee	22	2. Name and Address of Facility	MimoRiv	1	2834
m	Depar Impo		Jan West		1 5	NAU CHOUSE CE	an Peral	VILLE MAGN	100
			23a. Part1. Enter the disease, or com	plications that caused the dea	th. Do not ent	er the mode of dying, such as cardi	ac or respiratory arre	st,	Approximate
	Pnysician		shock, or heart failure. List only Immediate Cause (Final	Byeu	el ·	Cancer			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as a conse		concer			
н	Examiner			*22 1	570-513	La borne	•	1	
		ē	Sequentially list conditions,	b. Due to (or as a nones		to booses demention	-		
$\sqrt{}$	be executed sician and burial-transit	Examiner	l any, leading to immediate cause. Enter Underlying Cause (Disease or injury	A1-20	· anir	1 dementio	l		
<u> </u>	al-tra	Xai	that initiated events resulting in death) Last	C. Due to (or as a conse	quence of):	60			
8760,	cate be executed physician and the burial-transit	dlcal		Haspy	tersi	/			
89		edlo		u					
×	The law requires that the death certific Ite has been signed by the attending p age 2 should be detached for use as	W/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr	nancy			23d. Date of deliver	v
Вох	atter atter	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)			Day Year
O.	the d	ıysı	1 ☐ Yes 2 █ No 9 ☐ Unknown	9□ Unknown					
<u>α</u>	that the de led by the a detached		Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause given in Part I.	23e. Did toba	icco use contribute to the	e cause of death?
ds	sign d be	d by		<b>\</b>			1 ☐ Yes	2 □ No 3 □ Proba	ibly 4 Unknown
Ö	w requirence been something	Completed							
36	has has 3e 2 s	ldμ					24a. Was an autopsy perform	prior to corr	sy findings available ipletion of cause of
a		S						INo 1 ☐ Yes	2 No
Vital Records,	Physicien: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Haspitalt			eath (Check only one	)	
of	dis y	7	1 ☐ Yes 2 ☑ No		ER/Outpatier			ce 6 Other (Specify,	)
n		on:	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work?	28d. Describe hov	injury occurred	
Division	tsn leat tor: the	Certification:	2 Accident investigatio 3 Suicide 6 Could not b	A		M 1 ☐ Yes 2 ☐ No			
Ξ	or Attsno after deatl Director: In by the	rtii	4 Homicide determined			eet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by			M					
	Hosp 4 hol Fune ely fi	edical	(Check only 2 Medical Exac	miner: On the basis of examin	owledge, death ation and/or in	n occurred at the time, date and place vestigation, in my opinion, death occ	ce, and due to the cau	ise(s) and manner as sta e and place, and due to	ited. the cause(s)
	the hin 2 the nplet	Med	0110)	and manner stated.					
	To To	~	29b. Signature and title of certifler	(		29c. License number		d. Date signed (Month, D	•
,	/			5		252749		06/05/05	
	16		30. Name and address of person who		1	*			
	17		2. Hilbiatra mg		er dru		3 5/50		
	Sta		JUN 0 7 29	Registrar's Sign	ature	الناف			
	Registr	ar	2011 0 1 50	per se	163900				

			1 - State State Registrar	of Maryland		artment of H		Mental Hygi	ene 0 0 5	18882
	Physici	an	Decedent's Name (First, Middle, Last)     ALICE	C. ARNO	ΛT			2. Date of Death Month	Day Yea	
	/Medic	al	4a. Facility Name (If not institution, give street and n			4b. City, Town, or	Location of Death	JUNE	4, 2001 4c. County of De	
	Examin	er	Saint Joseph Medica	al Cente	10		Towso			timore
	Funeral Director		5. Social Security Number 220-48-0924 6. Sex 1 ☐ M 2 1	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 11-27-1	9. E	Sirthplace (State or Foreign Country) MARYLAND
	yland Now		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	ocation				10d. Inside City Limits
	e Man	ctor	MD. BALTIMORE			TOWS	ON			1 □ Yes XXNo
	23e or 20	Funeral Director	10e. Street and Number 1055 WEST JOPPA ROA	AD.		10f. Zip Code	21204	10	g. Citizen of What	
036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 Is marked other then "neturel, or Items 23e or 28a-f show other treumatic event, the Madical Exp. item from be notified at	by	Armed	; <b>2XX</b> No Sive		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes XX No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ar Black, Wi Specify:	merican Indian, hite, etc. WHITE
5-0	"netur	eted	15. Decedent's Education (Specify only highest grade completed	1)	(Give	dent's Usual Occupa	furing most of wor	rking	6b. Kind of Busines	ss/Industry
21215-0036	e filed within al Hygiene. I other then '	Completed		(1-4or 5+) ARS	iife. i	DO NOT use retired HOUSEWIF			OWN H	IOME
Maryland	ould be filed Mental Hygid arked other atic event, II	To Be C	17. Father's Name (First, Middle, Last)  WILLIAM		WIE		18. Mother's Nar	ne (First, Middle, Mi	williams	
	ind 2 should be alth and Mental alth and Mental 27 Is marked or treumatic ev		19a. Informant's Name/Relationship (Type, Print) NATHANIEL D.ARNOT, JR.	(SON)		-		ALTIMORE,	*	
altimore,	Pages 1 and 2 nent of Health int: If item 27 I iry or other tre		20a. Method of Disposition  1 □ Burial 2XXCremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	n State cen	netery, crer	sition (Name of matory or other plac SERVICE C			TOWSON, MA	or Town, State ARYLAND, 21204
Balti	permit. Pages. Department of H Importent: If ite any injury or ot once.		21. Signature of Funeral Service Licensee	(R.G.RUTH		2. Name and Addres		L HOME,IN	1050 C. TOWSO	YORK ROAD N,MD.21204
	Pnysician /Medical		resulting in death)	each line. IC SHOC	К	er the mode of dying	g, such as cardiad	or respiratory arres	st,	Approximate Interval Between Onset and Death B HOURS
	Examiner		BLAI	O (or as a conseque ODER INF		ON				3 DAYS
	p is	iner	cause. Enter Underlying	o (or as a consague	nce of a					
8760,	cate be executed physician and the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last C	o (or as a conseque	ince of):					
9	ertifical ling phy e as th	(a)	IF FEMALE:							,**
O. Box	that the death certifi ed by the attending detached for use as	Physician/M	23b. Was decedent pregnant 1 Live	utcome of pregnance birth 2 Petal dignant at time of deal crown	eath 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year
ds, P.	uires that signed by Id be deta	by	Part II. Other significant conditions contributing to	death but not result	ing in the u	nderlying cause give	en in Part I.	23e. Did toba		to the cause of death?  Probably 4  Unknown
Records,	The law requires that sate has been signed by page 2 should be detailed.	Completed		,				24a. Was an autopsy perform	prior to death'	autopsy findings available o completion of cause of
Vital		BeC	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one	<b>`</b>	as 2 No
of <	S S =	၉	1 ☐ Yes 2 📉 No Hospital: 1 🖸		R/Outpatien		4 🗆 Nursing 🗅	ome 5 Residen		pecify)
ono	ding After fune	tion		e of Injury 2 onth, Day Year)	l8b. Time of Injury	Work	at (? /es 2 ☐ No	28d. Describe how	injury occurred	
Division	after death after death I Director: d in by the	Certification;	3 Suicide 6 Could not be determined 28e. Pla	ce of Injury - At hom ding, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
	To the Hospitel or within 24 hours afte To the Funeral Director Completely filled in It	Medical C	29a. Certifier (Check only one)  Check only one)  1	ne best of my knowl basis of examinatio inner stated.	edge, death on and/or in	n occurred at the tim vestigation, in my op	e, date and place pinion, death occu	, and due to the cau rred at the time, dat	se(s) and manner e and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of celtifier	1	1	29c. License	number	290	d. Date signed (Mo	th, Day, Year)
ŀ	7		, 1000				098		6/7/	07
	20		30. Name and address of person who completed ca  DAVID A. UTZSCHNEIDE	R. M.D.	. 76		S DEIDE	. TOUSON	T MODVI	AND 21204
	Sta Registr	16	31. Date filed (Month, Day, Year) 7 2005 32.	Redistrar's Signatu	16 A	perte	The state of the s	7	<del>-9 111111</del>	the state of the s

			1 - For State Registrar	State of M		partment of ertificate of		d Mental Hygi	ene 0	5   8883
	Physici	an	1. Decedent's Name (First, Middle, Last Michele P. B	•				2. Date of Death Month June		3. Time of Death
	/Medic	al	4a. Fecility Name (If not institution, give	annister		4h Cih, Town	or Location of D		3, 200 4c. County of	
	Examin	er	9211 Kilbride Ro				tingham	eath		timore
	Funeral		5. Social Security Number 6. Se	x 7. Ag	e (In yrs. last birthda	y) If Under 1 Yea	r If Under 24 l	Hrs. 8. Date of Birth	l	Birthplace (State or Foreign Country)
в	Director		217-40-3003	]M 2[X[F	62 Yrs.	Months Day	s Hours N	Ain. 8. Date of Birth (Month, Day, Feb. 17,	1943	Maryland
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Maryl -f sho	tor	Maryland Baltimo	re		Nottingho	un			1 ☐ Yes 2 ☑ No
	h the	Irec	10e. Street and Number		1	10f. Zip Code		10	g. Citizen of Wh	hat Country?
	23a c	alD	9211 Kilbride Ro	ad		21	236		и.	.S.A.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23s or 28e-f show any injury or other traumatic event. It. Medical Examinat must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 🛣 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 💢 If Yes, Give	Ever in U.S. 1	Was Decedent of If Yes, specify Cu     1 ☐ Yes 2 ☑ N		? (Specify Yes or No- uerto Rican, etc.)	Black	- American Indian, s, White, etc. White
Ö	hour tural	ed b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates:	16a De	edent's Usual Occ	unation	11	6b. Kind of Bus	
75	nin 72 n "na Medis	plet	(Specify only highest grad		(Gi	re kind of work don DO NOT use reti	e during most of	working	D. Killa of Bas	iness/industry
212	ad with	Completed	12th Grade	College (1-401	S	ecretary			Law Fi	irm
Baltimore, Maryland 21215-0036	uld be filk flental Hy rked oth tic event	To Be	17. Father's Name (First, Middle, Last)  Oscar Pullium				18. Mother's	Name (First, Middle, M S	aiden Sumame, 'ECUSON	J
lary	2 should have and have ls mains		19a. Informant's Name/Relationship (T			-		Rural Route Number,	-	
e,	1 and Health Iam 27 other ti		Gerald Bannister  20a. Method of Disposition	(husban		I KULDTUO position (Name of ematory or other p		Baltimore,		1236 City or Town, State
mo E	Pages ent of nt: If It		1 Durial 2 Cremation 3 II 4 Donation 5 Other (Specify,		i		1			re Maryland
alti	Departm Departm Importa any inju		21. Signatur Fundi Service Licens		Zoudon	22. Name and Add	Iress of Facility	Schimunek F	uneral	Homes
0	20 E E 9		D OYTH			9705 Bel	lair Rd.,	, Baltimore	, MD 21	1236
	Priysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	ne cause on each li	d the death. Do not one.	nter the mode of d	ying, such as care	oows Price	5 A N. ]	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					
	led nsit	nlner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as	a consequence of):					
,	death certificate be executed e attending physicien and buf for use as the burial-transit	Examine	Africa initiate of accompany	c. Due to (or as	a consequence of):					
8760,	ysicial	dical		d						
9	ntifica ng ph	Medi	IF FEMALE:							
Box	attending for use as	ian/i	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	□Ectopic pregnar			23d. Date Mont	of delivery th Day Year
0		Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of death	☐ Other (specify)				,
Δ.		by Ph	Part II. Other significant conditions co	ntributing to death b	out not resulting in the	underlying cause (	given in Part I.	23e. Did toba	cco use contrib	bute to the cause of death?
ords	w raquira baan sig should b	led k						1 ☐ Yes	2 🗓 No 3	3 Probably 4 Unknown
Vital Records,	2 2	Completed						24a. Was an autopsy	pri	ere autopsy findings available for to completion of cause of
<u> </u>		Con						performe 1 ☐ Yes 2 li		eath? ☐ Yes 2 ☐ No
Vita	Physicien: Th rthis certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			)thor	Death (Check only one.		
oţ		. To	1 ☐ Yes 2 📆 No  27. Manner of Death	1 ☐ Inpatie 28a. Date of Inju (Month, Da		of 28c. In	ury at	g Home 5 X Residen 28d. Describe how		, ,
ion	nding ath. r: Afte e func	atlor	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year) Injur	W	lork? □Yes 2□No			
Division of	To the Hospitel or Attanding within 24 hours after death. To the Funeral Diractor: Afte completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In- building, et	ury - At home, farm, c. (Specify)	street, factory, offic	е	28f. Location (Stre City or Town,	et and Number State)	r or Rural Route Number,
	ospitel hours a uneral I		29a. Certifier 1 ☑ Certifying Phy	sician: To the best	of my knowledge, de	ath occurred at the	time, date and pl	ace, and due to the cau	ise(s) and man	ner as stated.
	To the Hospitel within 24 hours To the Funeral completely filled	Medical	(Check only 2 Madical Exami	iner: On the basis of and manner st	f examination and/or	investigation, in my	opinion, death o	ccurred at the time, dat	e and place, an	nd due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier				nse number	290	I. Date signed (	(Month, Dey, Year)
•	$\alpha$		711/m	X ,	feeth (It-= 00 ) T		118320		66	05
6	)		30. Name and address of person who o	ompleted cause of c	leath (Item 23a) (Typ		humhal	rile MS 2	1093	
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature	Conti	,		. 13	
	Registr	ar	0014	1	State of the	1				

9500-51 To the state of the sta	Day Year 2005  4c. County of Death  Baltimore City 9. Birthplace (Ste Country)  10d. Insid 1  1. Citizen of What Country?  nited States 14. Race - American Indian Black, White, etc.  Specify: White b. Kind of Business/Industry ducation	de City Limits
5202 St. Albans Way  5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  6. Sex  1 □ M 2 □ F  71  The security Number  71  The security Number  71  The security Number  159-28-8796  Usual Residence of Decedent  Baltimore  8. Date of Birth (Month, Day, Yrs.)  Months Days Hours Min.  01/01/19	Baltimore City (sear) 9. Birthplace (Ste Country) 9.34 PA  10d. Insid 12 1. Citizen of What Country?  nited States 14. Race - American India: Black, White, etc.  Specify: White b. Kind of Business/Industry ducation  iden Sumame)	de City Limits
Usual Residence of Decedent	10d. Inside 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Yes 2□No
MD Baltimore City Baltimore  10f. Zip Code  10g  10g. Street and Number  11g. Was Decedent Ever in U.S. Amed Forces?  11g. Was Decedent Ever in U.S. Amed Forces?  11g. Never Married 2g Married  3g. Widowed 4g. Divorced  11g. Specify only highest grade completed)  15g. Decedent's Education  (Specify only highest grade completed)  16g. Decedent's Usual Occupation  (Give kind of work done during most of working life. Do NOT use retired)  17g. Father's Name (First, Middle, Married life. Do NoT use retired)  18g. Mother's Name (First, Middle, Married life. Do NoT use retired)  17g. Father's Name (First, Middle, Married life. Do NoT use retired)  18g. Mother's Name (First, Middle, Married life. Do NoT use retired)  19g. MD  10g. Street and Number  10g. Street and Number  10g. Street and Number  10g. Street and Number  11g. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11g. Yes 2g. No Specify:  16g. Was Decedent's Usual Occupation  (Give kind of work done during most of working life. Do NoT use retired)  17g. Father's Name (First, Middle, Married life. Do NoT use retired)  17g. Father's Name (First, Middle, Married life. Do NoT use retired)  17g. Father's Name (First, Middle, Married life. Do NoT use retired)  17g. Father's Name (First, Middle, Married life. Do NoT use retired)	nited States  14. Race - American Indian Black, White, etc.  Specify: White b. Kind of Business/Industry ducation iden Sumame)	
15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Decedent's Usual Occupation (Give kind of work done during most of working life. Do NoT use retired)  Elementary/Secondary (0-12)  Teacher  16. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NoT use retired)  Teacher  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Ma	ducation	
To 是主要 17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Ma		
The second secon	ity or rown, State, Zip Code)	
Brian J. Bohner  20a. Method of Disposition    Burial 2   Cremation 3   Removal from State   '4   Donation 5   Other (Specify)   Chesapeake Crematory   200.5   Between the state   200.5   Between th	MD 21212 c. Location - City or Town, State	
8717 Green Pastures Drive Bal	tives ltimore, Marvlar	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	Interval	imate I Between and Death
fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		
The property of the property o	23d. Date of delivery Month Day	Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  1	co use contribute to the cause	
The state of the s		ngs available of cause of
27. Manner of Death 28a. Date of Injury 28b. Time of Injury 2b.		
Solution of the control of the contr	se(s) and manner as stated	
Consect only 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and manner stated.  29b. Signature and title of certifier  29c. License number  D 54937	and place, and due to the caus  Date signed (Month, Day, Yea	se(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Martin C. Clowse, Mp 6701 N. Charles St, Rm 5105, Ba  State  31. Date filed (Month, Day, Year)  11 N 0 7 2005  32. Registrar's Signature	Gimore MD	21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year <u>12:</u>00<sup>A<sub>M</sub></sup> **Physician** June 2005 Joseph Bungori, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 1223 Paul Martin Drive Harford Edgewood If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1)0 M 2□F Yrs. 60 Director 12/19/1944 MD 215-42-5352 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Edgewood Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21040 United States Itama 23a 1223 Paul Martin Drive Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If res, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 No Specify: White Specify: δ 3 ☐ Widowed 4 ☐ Divorced ear or Dates: 1966-1967 Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Transportation Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 12 permit. Pages 1 and 2 should be filed Department of Health and Mental Hygic Important: If item 27 Is marked other: any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nora Ella Odell Joseph Bungori, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen Bungori/Wife Martin Drive Edgewood, MD 21040 1223 Paul 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place Jun 5 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory Inc. 2005 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MON SMALL CELL LUNG CANCER POORLY DIFFERENTIATED Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 4☐Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 sesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: After Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation

fungori, Joseph Division of Vital Rec

after death

Hospital or Attanding To the Hospital of within 24 hours af To the Funeral D completely filled in

1 Natural 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

D26

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANUSHA. SIRITHMA 2112 BELAUR ROAD, SUITEIU, FALLSTON MD 21047

State Registrar

Medical

31. Date filed (Month, Day, Year) JUN 0 7 2005 Registrar's Signature

				ate of Maryl	and / Depa		Health and N	Mental Hygi	211115	10006
			1 - State Registrar  1. Decedent's Name (First, Middle, Last)		Cer	uncate of	Death	2. Date of Death	g. Nó; U U U	3. Time of Death
	Physici /Medic		Richard Hey	wood Beck	ley			JUNE 2,	2005 Year	
	Examin		4a. Fecility Name (If not institution, give street 16449 Ed Warfield R	and number) load			or Location of Death		4c. County of Dea Howar	ith
	Funeral Director		5. Social Security Number 296-24-8456 6. Sex 149 M	7. Age (In y 75	rs. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, NOV 18,	(ear) 9. Bir 1929	rthplace (State or Foreign ountry) Ohio
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Many e-f sh	tor	Maryland Howard			Woodbi	ne			1 ☐ Yes 2 📉 No
	or 28	Oire	10e. Street and Number			10f. Zip Code		10	g. Citîzen of What C	ountry?
	s 23e	rai	16449 Ed Warfield Ro		-110 1101	Was Davidson of	21797		USA	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other then "natural; or items 23s or 28e-1 show other treumatic svent, the Medical Exam are must be muitible at	by Funeral Director	1 Never Married 2 Married 1	as Decedent Ever in med Forces? ÖYes 2 □ No 19 Yes, Give ear or Dates:195	948-51 ,	Vas Decedent of Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specity:	ecny Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
15-0	"natu	Completed	15. Decedent's Education (Specify only highest grade con	pleted)	(Give	ent's Usual Occu kind of work done	during most of work	king 10	6b. Kind of Business	/industry
121	withIn ene. then '	этрі	Elementary/Secondary (0-12) C	ollege (1-4or 5+)		00 NOT use retire todian	əd)		Schools	3
<b>d</b> 2	e filed withIn al Hyglene. f other then ' vent, the Me		17. Father's Name (First, Middle, Last)		Cus	LOUIAII	18. Mother's Nam	e (First, Middle, Ma		2
/lan	Aental Aental rked tlc sv	To Be	Floyd B. Beckley				Doris	M. Zay		
, Maryland 21215-0036	1 and 2 should be 1 Health and Mental I tem 27 is marked of other treumatic sve		19a. Informant's Name/Relationship (Type, P Kathryn B. Beckley/w	,					City or Town, State, Lne,MD 21	
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Remove		b. Place of Dispo- cemetery, cren Metro Cr				Oc. Location - City or $8a1 { t timore}$ ,	
altin	그런던 중 .		4 □ Donation 5 □ Other (Specify)  21. Signature of un ral Service Lieensee	James de la la					and, Inc.	
m	permi Depa Impo eny ii		Dawn F. McDona	ald					nore, MD 2	
	Fnysician /Medical Examiner	- O	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ns that caused the dise on each line.  Due to (or a a control of the disease)  Due to (or as a control of the disease)	sequence of):	er the mode of dy	ng, such as cardiac	or respiratory arres	it,	Approximate Interval Between Onset and Death  Z years
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.O. Box	The law requires that the death certificate be executed sie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	yes, outcome of pre   Live birth   2   F   Pregnant at time o	etal death 3 [	Ectopic pregnand Other <i>(specify)</i> _	у		23d. Date of de Month	livery Day Year
rds, P	quires that in signed b uld be deta	by	Part II. Other significant conditions contribut	ing to death but not	resulting in the ur	iderlying cause gr	ven in Part I.			o the cause of death?
al Records,		Completed						24a. Was an autopsy performs	prior to	utopsy findings available completion of cause of
Vital	Physician: Th r this certificete ral director, pag	o Be	25. Was case referred to medical examiner?	al:	T-0/0-1	Ot Do. Ot		th (Check only one)		
of	y Phys er this eral di	n: To		a. Date of Injury	2 ☐ ER/Outpatien 28b. Time of	28c. Inju	her: 4 Nursing Hory at	28d. Describe how	ce 6 Other (Spe injury occurred	ecify)
ion	Attending P death. ctor: After i y the funera	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year	r) Injury		rk? ]Yes 2∐No			
Division	T P C	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28	e. Place of Injury - A building, etc. (Sp	t home, farm, streecify)	et, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	To the Hospital of within 24 hours at NTo the Funeral D completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner: 0 a	To the best of my on the basis of examind manner stated.	knowledge, death sination and/or inv	occurred at the trestigation, in my	me, date and place, opinion, death occur	and due to the cau red at the time, dat	se(s) and manner a e and place, and du	s stated. e to the cause(s)
)	To that a within 2 To the complet	Σ	29b. Signature and title of certifier	X-0	Physicia	29c. Licen H 58	se number $5132/M$	290	Date signed (Moni	/ZP\$5
_	J		30. Name and address person who completed the part of	,DO. ; 7	\$80 Lis	bon Cert	er Dr., Wo	adbine, 1	MD 217	97
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	Span				

				epartment of Health and Mo Certificate of Death	ental Hygiei Reg.	4000	18887
ı	Physici /Medic		1. Decedent's Name <i>(First, Middl</i> e, Last) <b>Charles Buellis</b>		2. Date of Death Month June	Day 2005	3. Time of Death 10:35 A M
	Examir		4a. Facility Name (If not institution, give street and number) 7846 Tick Neck Road	4b. City, Town, or Location of Death Pasadena		4c. County of Death Anne Ar	undel
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth $216-16-0703$ $1 \times 10^{-1}$ $\times 10^{-1}$	day) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye FEB 8, 19	0 Riethe	place (State or Foreign
	ow or		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town	or Location		1	0d. Inside City Limits
	e Man 8e-f sh	Director	Maryland Anne Arundel	Pasadena			1 □Yes 2 □ No
	with the	Die	10e. Street and Number 7846 Tick Neck Road	10f. Zip Code 21122	10g.	Citizen of What Cour USA	ntry?
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic avent, it a Madical Examinate must be multilled at ance.	/ Funeral	11. Marital Status  1 Never Married 2 Married 2 Married 2 Narried 2 Narried 2 Narried 2 Narried 2 Narried Narried 2 Narried Na	Was Decedent of Hispanic Origin? (Speciff Yes, specify Cuban, Mexican, Puerto F     □ Yes 2  No Specify:	cify Yes or No- tican, etc.)	14. Race - Americ Black, White,	
21215-0036	n 72 hours '*natural', edical Ex	Completed by	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of workin ile. DO NOT use retired)	g 16b	. Kind of Business/Inc	
212	filed within Hygiene. Ither than ant, It e We	omo	Elementary/Secondary (0-12) College (1-4or 5+)	Bus Driver		Baltimore	City
	otal Hy ed othe savent,	Be	17. Father's Name ( <i>First, Middle, Last</i> )  Charles Buellis	18. Mother's Name		den Sumame)	
Maryland	2 should be and Mental is marked c	으	19a. Informant's Name/Relationship (Type, Print) 19b. t	Mailing Address (Street and Number or Rural		ty or Town, State, Zip	Code)
	1 and 2 Health a Sm 27 is					MD 20816 Location - City or To	Ctata
Baltimore,	permit. Pages Department of H Important: If ite any injury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)  Cometery,  Metro	crematory or other place) Crematory, Inc. 6/6/0	05	Baltimore	
Ba	Depar Depar Impor any ir		21. Signature of Funeral Service Licensee  Thomas Gregor	<sup>2</sup> Clemations Society ( 299 Frederick Road	Baltimo	nd, Inc. re, MD 21	228
	Pnysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	to enter the mode of dying, such as cardiac or the Concordian	respiratory arrest,		Approximate Interval Between Onset and Death
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Divis	al or Atta s after de: al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	Bf. Location (Street City or Town, St	and Number or Rura ate)	l Route Number,
	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/and manner stated.	death occurred at the time, date and place, are or investigation, in my opinion, death occurred	d at the time, date a	and place, and due to	the cause(s)
•	To the within 2 To the complet	Σ	29b. Signature of title of certifier	29c. License number	29d. l	Date signed (Month, 1	LOOS
/	7		30. Name and address of person who completed cause of death (Item 23a) (T	ype Print) Hospital Dri	ve, Ok	Burn	4.406/
	Sta Registr		31. Date filed (Month, Day, Year)  JUN 0 7 2 95  Substitute	to speak			. )

			1 - For Stata Registrar	State of Maryland	Certifica	nt of Healt te of Dea			giene 005	5   18888
	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle) Last JOYCE LY  4a. Facility Name (If not insylution, give HANNIS COULE)	VN BAUCHER		Joiner- Jown, or Locati	Bayshor	2. Date of Dea Month	Ac. County of De	3. Time of Death  3. Time of Death  1114 M  aath
	Funeral Director		Social Security Number 6. Sec.			r 1 Year If Un	der 24 Hrs.	8. Date of Birth Month Day	h 9. E	Birthplace (State or Foreign Country) Cyland
	the Maryland 28e-f show otified at	Director	10a. State 10b. County  Maryland Frede		own or Location		unswic			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	23a or 3	al Dir	8 Ninth Avenue		101. 2	21716			10g. Citizen of What i	Country? SA
9800	J within 72 hours after death with the Maryland jiene. rithen "natural", or Itams 23a or 28e-f show Ithe Medical Examination must be notified at	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ঐDivorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	13. Was Deco	edent of Hispanic ecify Cuban, Mex 2 No Spec		cify Yes or No- lican, etc.)	14. Race - Ar Black, WI Specify:	nerican Indian, nite, etc. White
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	12 sh hand 7 fsm traum		19a. Informant's Name/Relationship (Ty Angela Armstrong/P		9b. Mailing Addres			Route Numbe	r, City or Town, State	, Zip Code)
Baltimore,	Pages 1 ment of He ant: If itan ury or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 1 □ Donation 5 □ Other (Specify)	emoval from State 20b. Place come Metr	of Disposition (Na etery, crematory or O Cremato	other place) Ory, Inc	6/4/0	)5	20c. Location - City of Baltino:	
Bal	permit. Pag Department Important: I any injury c once.		21. Signature of Funeral Service bicensor  Edward Gregore	11	22. Name a Crema 2.99 F	nd Address of Fa Lion Soc cederick	iety of	f Maryl	and, Inc.	1222
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. D	we Can	de of dying, such Uai W	as cardiac or	respiratory arr	est,	Approximate Interval Between Onset and Death
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	To the Hospitel or Attending Phymythic 24 hours attendestly. To the Funerel Director: Alier th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)				f. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,
	le Hospitel 124 hours a la Funarel I letely filled	edical C	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of my knowled ler: On the basis of examination and manner stated.	lge, death occurred and/or investigation	at the time, date n, in my opinion, c	and place, and death occurred	d due to the call at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
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$\int$	0		30. Name and address of person who co James Cushman,		a) (Type, Print) Shock Tra	una	Balti	more, M	TD_	
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registrar's Signature	H	Engels)				

ORIGINAL

			State of Maryland / Dep	artment of Health and M	•	•				
			Registrar	rtificate of Death		g. N6- UUD 18889				
	Physici	an	1. Decedent's Name (First, Middle, Last)		<ol><li>Date of Death Month</li></ol>	Day Year				
	/Media	cal	JoAnn Benton	41. Oh. T	June	4, 2005 2:05 P M				
	Examir	ier	4a. Facility Name (If not institution, give street and number) 8305 Fremont Place	4b. City, Town, or Location of Death New Carrolltor	`	4c. County of Death Prince George's				
	F		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday			9. Birtholace (State or Foreign				
	Funeral Director		206-26-1926 1□ M 2X F 71 Yrs.  Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth June 11,	9. Birthplace (State or Foreign Country) Pennsylvania				
	land ow		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits				
	Man	ţō	Maryland   Prince Georges   New Car	rollton		1 ☐ Yes 2√7 No				
	or 286	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?				
	23a	ai	8305 Fremont Place	20784		USA				
	tams	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.				
36	be filed within 72 hours after death with the Maryland that Hyglene. Id other than "natural", or Itams 23a or 28e-f show event, Ita Madical Exemitter chat be multipled at	by Fe	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2☐ No If Yes, Give Year or Dates:	1 ☐ Yes X No Specify:		Specify: White				
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Maryland	d 2 sh th and 7 le n traun			ing Address (Street and Number or Rura						
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JO L	Pages nent of int: If it		1 Liburial 2 Cremation 3 Linemoval from State	1		Baltimore, Maryland				
Baltimore,	교 된 본 분 .									
m	Depa Depa Impo any i		Thomas Gregor	Name and Address of Facility Society Control Frederick Road	i Maryla Ballimor	ind Inc. e. Maryland 21228				
	Physician /Medical Examiner	ler	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							
Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as a consequence of):  d.  IF FEMALE:  23c. If yes, outcome of pregnancy  23d. Vas decedent pregnant			23d. Date of delivery				
o.	that the death ted by the atte detached for i	Physician/Med	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		Month Day Year				
rds, P.	quires that n signed t uld be det	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to the cause of death?				
Records,	Tha law require te has baen si age 2 should b	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  No 1 7 yes 2 No				
Vital	yeician: Tha is certificate hi diractor, page	Be C	25. Was case referred to medical examiner?	26. Place of Death						
of V		10	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatie	ont 3 DOA Other: 4 Nursing Ho	me 5 <b>X</b> Residen	ce 6 Other (Specify)				
	ding Ph h. After th funeral		27. Manner of Death 1	Work?	28d. Describe how	vinjury occurred				
Sio	Attending r death. sctor: After by the funer	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s	M 1 Yes 2 No	79f Lagation (Stra	eet and Number or Rural Route Number,				
Division	in Signal	Certification:	4 Homicide determined building, etc. (Specify)	теві, іасіоту, опісв	City or Town,					
	To the Hospital or Attenwithin 24 hours after deat to the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal of the control of the pass of examination and/or in and riganine stated.	th occurred at the time, date and place, ovestigation, in my opinion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as stated. e and place, and due to the cause(s)				
	within for the comple	Me	29b. Signature and title of continue	29c. License number	290	d. Date signed (Month, Day, Year)				
١			Non The	D20352		(9/8/Q)				
1	8		30. Name and a cross of erson who completed thus of death (Item 23a) (Type	De WeberARA L	I a	Twon MD				
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 7 20 Registrar Signature	29c. License number  DOS 52  Print)  Character Aces A		J				

		1- State of Maryland / Department of Health and Certificate of Death	Mental Hy	giene	5 18890
Physic	ian	1. Decedent's Name (First, Middle, Last)	2. Date of D	Day	Year 237 2 M
/Med Exam		Theodore W. Buffalo  4a. Facility Name (If not institution, give street and number) / 4b. City, Town, or Location of Dea	June	4c. County	of Death
		Maryland General Hospital Bulfinial C	744		N/A
. Funera Directo		5. Social Security Number 214-62-8730 6. Sex 7. Age (In yrs. last birthday) 1f Under 1 Year   If Under 24 Hrs. Months   Days   Hours   Min   Months   Days   Hours   Min   Months   Min		2, 1955	9. Birthplace (State or Foreign Country) Mary Land
₽ >		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		2, 1,555	
A / O death with the Maryland ms 23e or 28e-f show croust be notified at	jo				10d. Inside City Limits 1 XYes 2 ☐ No
or 28a	irec	10e. Street and Number 10f. Zip Code		10g. Citizen of V	/hat Country?
ath will	rai	1338 Pentwood Road 21239			USA
or Item	Funeral Director	11. Marital Status  1 \( \times \) Never Married 2 \( \times \) Married  12. Was Decedent Ever in U.S. Armed Forces? 1970  1 \( \times \) 2 \( \times \) No 2 \( \times \) No Specify:  1 \( \times \) Yes 2 \( \times \) No Specify:	rto Rican, etc.)	0- 14. Hace Blac	e - American Indian, k, White, etc.
MATANO 15-0036 172 hours after death with the Marylar "neturel", or Items 23a or 28a-f show wife. Examples from the maillised at	d by	3 Wildowed 4 Divorced Year or Dates: 1974		Specify	DIACK
	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of work done	orking	16b. Kind of Bu	siness/Industry
d 21211 filed within "Hygiene" soft, the Ms.	Com	Elementary/Secondary (0-12) College (1-4or 5+) Cook			aurant
The World Street, Maryland 212- st and 2 should be filed within at Health and Mental Hygiene. item 27 is marked other then other treumatic event, the Maryland Street, when the month of the street.	To Be	77'11' D CC 1	am <i>e (First, Middle</i> a Smith	e, <i>Maiden Sum</i> am	9)
laryla and Men is marke	F	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Fi		ber, City or Town,	State, Zip Code)
e, M tealth		Bernadette Harris, Sister 1938 Pentwood Road Ba	altimore Date		nd 21239 City or Town, State
		1 ☐ Burial 2 MCremation 3 ☐ Removal from State	03/05		ce, Maryland
Baltimore, Maryland 212 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other then eny injury or other treumatic event, the Money.		21. Signatura of Funeral Sex Sections 22. Name and Address of Facility Cremation Society	Of Mar	vland Ind	
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	ad Balti	nore, Mai	ry Land 21228 Approximate
Physician		shock, or heart failure. List only one cause in each line.  Immediate Cause (Final disease or condition  CULBE SEPS 'S			Interval Between Onset and Death
/Medica Examiner		Pue to (or as a consequence of):  ACQUIRED Immunodeficien	110 (1)	ndrom	2
	Jer	Sequentially list conditions	cy cy,	MOIOTA	
60, be executed ician and burial-transii	Examiner	Cause Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
8760, cate be executed obysician and the burial-transit					
c 687 ortificate ing physi	Medi	IF FEMALE:			
Box 68 leath certifica attending ph	Physician/Medical	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date Mor	e of delivery hth Day Year
P.O. hat the de de detached	hysi	1 U Yes 2 No 9 Unknown 9 Unknown			
cords, P.O. Box 687 requires that the death certificate been signed by the attending phys should be detached for use as the	b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			ibute to the cause of death?  3 Probably 4 Dunknown
© ≥ 0 v	Completed		24a. Was	s an 24b. V	Vere autopsy findings available rior to completion of cause of eath?
Vital Resident The lasticate ha	e Cor		1 ☐ Yes	2 No 1	Yes 2 No
of Vita Physicien: this certifica	To B	examiner?		idence 6 □Othe	r (Specify)
On O ding Pl h. After th		27. Manner of Death  1 Anatural 5 Pending (Month, Day Year)  28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?  1 Accident investigation M M 1 Pess 2 No	28d. Describe	how injury occurre	∍d
Division of Vital Records, I or Attending Physicien: The law requires tatler death.  Director: After this certificate has been signed in by the tuneral director, page 2 should be	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Number	or or Rural Route Number,
Dipital o			and due to the	a course/s) and ma	anner og stated
Division of Vital Reconstruction of Vital Reconstructi	ledical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	surred at the time,	, date and place, a	nd due to the cause(s)
To with To con	Σ	20534	5	Coli	(Month, Day, Year)
14 1×		30. Naghe and address of a roon who completed cause of death (Item 23a) (Type, Print)	repal,	LOSPIT	tal
	tate	31. Date filed (Workin, Day, 1947) 32. Hegistrar 3 capitature	10,000	7	
Regis	trar	JUN 0 7 2005 Stew S. Aprile			

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 = For State Registrar			epartment of F Certificate of		Reg	ene 0 0 5	18891		
	• Physici		1. Decedent's Name (First, Middle, Last)  George E. E					2. Date of Death Month June	2, 2005	3. Time of Death 12:50PM		
1	/Medic Examir		4a. Facility Name (If not institution, give	street and number)			r Location of Death		4c. County of Deal			
	Funeral		Joseph Richey Hos  5. Social Security Number 6. Sep	L	e (In yrs. last birtho		imore If Under 24 Hrs.	8. Date of Birth	·	hplace (State or Foreign untry)		
Ш	Director		220-30-6029 -	[M 2□F	67 Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Day, ) Feb 22,	1938 Vii	ginia		
	ow III		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits		
	a-1sh	ctor	Maryland N/A		Ва	ltimore				1 X Yes 2 ☐ No		
	death with the Maryland ms 23s or 28s-f show	al Director	10e. Street and Number 1700 Edmondson Av	renue Apt.	.407	10f. Zip Code	1201	100	g. Citizen of What Co USA	untry?		
	or Ite	by Funerai		12. Was Decedent It Armed Forces? 1 ☐ Yes 2 ② If Yes, Give Year or Dates:	Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: B	ncan Indian, a, etc. ack		
1215-	"natur	Completed	Lieinentary/secondary (0-12)   College (1-40/5+)				dent's Usual Occupation kind of work done during most of working DO NOT use retired)  ninistration			. Kind of Business/Industry  Hospital		
land	z should be tiled within and Mental Hygiene. Ia marked other than raumatic event, the M	To Be C	17. Father's Name (First, Middle, Last)  James A. Brent					e (First, Middle, Ma Sie E. Ket	,			
<b>lar</b> y	ges 1 and 2 should it of Health and Mer If item 27 la marke or other traumatic		19a. Informant's Name/Relationship (Ty			ailing Address (Street						
ē,	Health tem 27 other t		Phyllis Brent, Wif	e		East 33rd sposition (Name of crematory or other place			Mary Land  C. Location - City or			
E O	Pages nent of int: If it		1 ☐ Burial 2 Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Metro C	crematory or other plac Crematory I	$\frac{e}{2}$ 06/03	3/05 B	altimore,	Maryland		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra 2002e.		21. Signature of Funeral Service License Thomas Gregor ()	and Inc. re, Maryla	and 21228							
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Bra	. 1		ng, such as cardiac	or respiratory arres	t.	Approximate Interval Between Onset and Death		
68760,	ean centificate be executed attending physician and for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Justes 2) if yet that initiated events resulting in death) Last		a consequence of): a consequence of):							
. Box	2 0 5	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	1		23d. Date of deli Month	very Day Year		
	w requires that the been signed by th should be detache	þ	Part II. Other significant conditions cor	1.5		e underlying cause giv	ren in Part I.		cco use contribute to			
al Rec	ate has b	Completed							prior to death?  No 1 □ Yes	topsy findings available completion of cause of		
_	fter this	tion: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1  Inpatie 28a. Date of Injur (Month, Day	v 28b. Tim	e of 28c. Injur	er: 4 Nursing Ho	h (Check only one) me 5 Residence 28d. Describe how	ce 6 Other (Spec	Hospice		
Divis	To the nospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	iry - At home, farm.	street, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,		
:	in 24 hour the Funera pletely fills	edical	29a. Certifier (Check only one)  12 Certifying Physical Control one)	sician: To the best of ner: On the basis of and manner sta	examination and/o	eath occurred at the tir r investigation, in my o	pinion, death occur	and due to the causered at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)		
	To t	Σ	29b. Signature and title of certifier			29c. Licens			d. Date signed (Month			
d			30. Name and address of person who so			pe, Print)	24170		June 2 re MD	, 2005		
T	)		E TSO MD R	ichey (to	spice 83	8 N.Ew	aw St	Baltimo	re MD	21201		
	Sta Registr	_	31. Date filed (Month, Day, Year) 0	7 2005 Regist	s Signature	· South						

State of Maryland / Department of Health and Mental Hygiene 0 05

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						Ce	rtificate	e of	Death		1	Reg. No.		1 0	0 2 6
			ne (First, Middle, La	st)							2. Dete of Dec Month	eth Dey	Year	3. Tim	ne of Death
	Physician /Medical	775-55	SIE	BASIKET	TE			1			JUNE		2005	10	20
	Examiner	4a Casilib, Nama	(If not institution, giv						4b. City, To	wn, or Lo	cation of Deeth				
100									Baltimore			N/A			
*	Funeral Director	5. Social Security 1 213-09-2		Sex I□M 2∏ F	7. Age (In yrs. 9		If Under Months	1 Year Days		24 Hrs. Min.	8. Date of Birt (Month, Da May 7,	n y, Year) 1907	9. Birthpl Count VA	ace (Sta try)	ate or Foreign
	P	Usuel Residence of			1.0 00										In Other Live has
	trytar thow	10a. State	10b. County			y, Town or Lo							10		le City Limits Yes 2 ☐ No
	a Na Para Sa	MD.	MD. N/A Baltimore X_19es 2  10e. Street end Number 10f. Zip Code 10g. Citizen of What Country?										163 21110		
	or 20									What Count	try?				
	23a 15a	6701 Rob	erts Aven	ue					222			USA			
	ifier death with the Mai r items 23s or 28s-f si ifirer must be notified Funeral Director	11. Maritel Status		12. Was Dece	dent Ever in U ces?	,S. 13.	Was Deced If Yes, spec	tent of h	Hispenic Or an, Mexica	igin? (Spo n, Puerto	ecify Yes or No Rican, etc.)		ce - America ck, White, e		n,
Maryland 21215-0020	a 1 end 2 should be filed within 72 hours efter death with the Maryland Fleath end Mental Hygiene. Health end Mental Hygiene. Item 27 is merked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Exercise must be notified at To Re Completed by Funeral Director.		ried 2 Married 4 Divorced	1  Yes If Yes, Give Yeer or Da	•		1□ Yes	2 <b>X</b> No	Specify:			Specif	v: Whit	te	
5	72 h natu alcal	(Spe	15. Decedent's E	ducation de completed)		(Give	dent's Usue	rk done	during mos	at of work	ing	16b. Kind of B	usiness/Ind	ustry	
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2	tal H	17. Fether's Neme	(First, Middle, Last	)									ne)		
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	1 end 2 sho Health end em 27 la me Ather traum	James Ba	Name/Relationship skette	Type, Print)	son			•				e, Md.		Code)	
Baltimore,		20a. Method of Dis	•	7D		Place of Disponentery, cre	osition (Nan matory or o	ne of ther pla	ice)	1	Date June	20c. Location	- City or To	wn, Stat	е
Ĕ			Cremation 3 Doctor   Comparison   Comparison			k Lawr	. Ceme	eter	У	, ,	,2005	Dundal	k,Md.		
att	permit. Page Depertment of Important: If any injury or page	21. Signature of F	uneral Service Lice	nsee	0	1 3	2. Name an	Addre	ss of Facili	y) H	ome Of I	Dundalk	РΔ		
m	Pen Jany Sun	1 Mart	Thomas .	(in	nel			_				Dundalk		2122	2
	9	23a. Part1. Enter	the diseese or contact failure. List only	plications that ce	used the deet								,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Approx	imate
a Char	Physician	shock, or he	art failure. Ligt only	one cause on ea	ich line.								1		Between and Death
	/Medical	Immediate Ceuse			ND-STAGE DEMENTIA								0 40	105	
	Examiner	disease or conditi resulting in death)		e. END -		or as a conse		4					- 1	0 10	EARS
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	death certificate be executed etanding physicien and of for use es the buriel-transit stellar/Medical Examiner	Sequentially list o	Sequentially list conditions  Due to (or as a consequence of).												
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68760,	ysicii	Cause (Disease o	that initiated events Due to (or a												
	ding ph	resulting in death)	resulting in death) Last												
Вох	ettendin for use			d									1		
	at the death conditions at the ettend atteched for us	Part II. Other sign	ificant conditions	contributing to de	ath but not res	ulting in the u	inderlying c	euse gi	ven in Part	l.	23b. Did	tobacco use co	ntribute to	the cal	use of death?
P.0	that the de ned by the e dateched i										10	Yes 2 No	3 Prob	ably	4 🗆 Unknown
	as that igned be dated		24 ARTER	LY DISC	ease										
Records,	v requiras that the been signed by th should be dateche										24a. Was	an autopsy rmed?	24b. We	re auto	psy findings rior to
ပ္သ	aw reas bee													npletion leeth?	of cause
æ	9 H B										10	Yes 2 No	1 [	Yes	2 No
Vital	cartificata ractor, pag		erred to medical						26. Plac	e of Deet	h (Check only o	one)			
5			,	Hospital:	patient 2	FR/Outpatie	nt 3□ DC	OA Ot	her: 4□N	ursina Ha	me 5 Resid	dence 6 □Ott	ner (Specify	·)	
o	2 2 2			28a. Dete o	f Injury	28b. Time o		28c. Inju Wo				how injury occu			
Division	Attending Phore death.  Ctor: After the by the funaral	1 ⊠Natural 2 ☐ Accident	5 Pending investigation		h, Dey Year)	Injury	М		Yes 2□	No					
İSİ	or Attendiation after death. Director: A in by that	3 ☐ Suicide	6 Could not be determined	289. Place	of Injury - At h	ome, farm, st	reet, factory	y, office				Street and Num	ber or Rura	/ Route	Number,
á	5 # 5 E	4   Homicide	3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Could not be determined  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide					City or Town, State)							
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: complately filled in by tha Madical Centifical		12 Certifying Pi 2 Medical Exa	nysician: To the l miner: On the ba and mann	sis of exemina	owledge, deat tion end/or in	h occurred evestigation	at the ti	ime, date er opinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) and m date and place,	anner as st and due to	ated. the cau	ıse(s)
	of the vithin forther somple	29b. Signature and	d title of certifier		1		290	c. Licen	se number			29d. Date signe	d (Month, I	Day, Ye	ar)
	->-0	1	m( = 11	1	^		7	006	2032			JUNE	6 20	05	-
	10	30. Name and add	dress of person who	completed cause	of death (Iter	n 23a) (Tvpe	Plain4)								
	4	JENNIFE	R HAYASH	1 5505	HOFKIN	S RAYIL	ENC	180	LE F	BALTI	MORE	MO 21	1224		
8	State	31. Dete filed (Mo.		32. Re	gistrer's Signa	ature	4			11					
	Registrar	A.	HIM O 7	2005		H A	الملاقة	•							
			ANIA (	130		- 14									

		1 - For Stete Registrer	State of Marylan		urtment of Heatificate of De		ntal Hygier Reg. 1	6000	18893
Olymp		Decedent's Name (First, Middle, Last,					Date of Death		3. Time of Death
Phys /Me	ician dical	LORRAINE	JEAN BROY	KHG		13		Day Year	12:37 HM
Exan	niner	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Lo	cation of Death	1	4c. County of Death	
		5. Social Security Number 6. Se	7. Age (In yrs. I	ast hirthday)	If Under 1 Year If	Under 24 Hrs. 8	Date of Birth	DALT, MO	Plane (State or Corrige
Funera Directo			M 290F 33	Yrs.		Hours Min.	(Month, Day, Yea	ar) Cou	place (State or Foreign ntry)
p ,		Usual Residence of Decedent							
shov	5	10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2® No
286-1	Director	10e. Street and Number	045	·wel	10f. Zip Code		100.0	Citizen of What Cou	
1036 ours atter death with the Marylan rel', or Items 23e or 28e-f show Externing Lear Addited at		12261 Roundwood	o Rosa vos	-1217	( C)		, og. (	) ( A	nuy:
death	Funeral		12. Was Decedent Ever in U.S Armed Forces?		Vas Decedent of Hispa	anic Origin? (Specific	y Yes or No-	14. Race - Ameri	
36 s atter	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 No		Yes, specify Cuban, M	specity:	an, etc.)	Black, White,	etc.
21215-0036 within 72 hours all giene. er than "neturel", or the Medical Experi	q pe	3 ₩idowed 4 □ Divorced  15. Decedent's Edu	Year or Dates:				1.0	(M)	3771
7. 15 7. 10 7. 10	Completed	(Specify only highest grad	e completed)	(Give	ent's Usual Occupatio kind of work done duni OO NOT use retired)	ng most of working	160.	Kind of Business/In	dustry
2121 od within or than	E O.	Elementary/Secondary (0-12)	College (1-4or 5+)	Hor	NEWSKEV			OK TA	$Z^{\infty}$
nd be tile tal Hy d oth	Be	17. Father's Name (First, Middle, Last)	3.7		18	. Mother's Name (F	irst, Middle, Maide	en Sumame)	
Maryland 21215-0036 42 should be tiled within 72 hours atter death with the Maryland th and Mental Hygiene. 7 is marked other than "neturel", or items 23e or 28e-f show treumatic event, the Medical Evand actions the reddily	2		HIRCCKA			Anna		swick	
A d d d d d d d d d d d d d d d d d d d		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	g Address (Street and	Number or Rural R	oute Number, City	y or Town, State, Zip	(Code) 2,053
Te, 1 and Heal Heal	1 8	20a. Method of Disposition	20b. P!	ace of Dispo:	sition (Name of	Date	20c.	Location - City or To	own, State
n 00		1 ☐ Burial 2 ☑ Cremation 3 ☐ F	Sellioval Hom State	emetery, cren	natory or other place)	1 JUNE 5	1	Co 11 . 1	Challes
Baltimo permit. Pag Department Importent: any injury o	ouce.	21. Signature of Funeral Service Licens		111	Name and Address o		nerisi	131 Hill	1 31234
<b>n</b> && <b>E</b> & :	8	Hannell C	Soch	- 2	2800 HAR	FORD ROP	O PAR	KrillE M	arplysa
L. J.		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused the death ne cause on each line.						Approximate Interval Between
Pnysicial	_	Immediate Cause (Final disease or condition resulting in death)	_ chronic	: 06	structiv	e Lung	disens	se	Onset and Death  Season
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7	ie i	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ence of):					
18760, cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events							
SO, Se exe		resulting in death) Last	Due to (or as a consequ	ence of):					
80 s f	dlcal		l				· · · · · · · · · · · · · · · · · · ·		
Box 6 Box 6  Bath certification of the control of t	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnar	ncy				23d. Date of delive	201
B. Beath	by Physician/Me	in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de		Ectopic pregnancy Other (specify)			Month	Day Year
P.O. that the ded by the detached	hys	9 ☐ Unknown	9□ Unknown						
S. F. F. F. F. F. F. F. F. F. F. F. F. F.		Part II. Dther significant conditions con	1.	lting in the un	derlying cause given in	Part I.		use contribute to the	
cord w requir	eted	COVOMINY AVTER	y disease				1 🗌 Yes	2 No 3 Prob	ably 4 Unknown
A sa sa sa sa sa sa sa sa sa sa sa sa sa	Completed						24a. Was an autopsy performed?	prior to con	psy findings available mpletion of cause of
	e Co	25. Was case referred to medical				Pl	1□ Yes 2 N		2□ No
- S W =	To B	examiner?	ospital: 1   Inpatient 2   E	R/Outpatient		. Place of Death Control of Place of Death Control		6 ☑Other (Specifi	Hassica
	L:	27. Manner of Death  1 Natural 5 Pending		28b. Time of	28c. Injury at Work?		Describe how inj		Clospice
Vision Attending of death.	catle	2 Accident investigation 3 Suicide 6 Could not be			M 1 ☐ Yes	2 🗆 No			
in Signal	Certification;	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre	et, factory, office	28f.	Location (Street a City or Town, Sta.	and Number or Rura ite)	l Route Number,
Divisit Divisit Hospitel or Attent 44 hours after death Funerel Director:		Zsa. Cartifier 1 Certifying Phys	isian: To the best of my know	viecue, death	occurred at the time of	late and place, and	due to the causer	s) and manner as st	ated
To the Hospitel within 24 hours a To the Funerel I completely filled	edical	(Check only 2 Medical Examination)	ner: On the basis of examinati and manner stated.	on and/or inv	estigation, in my opinio	n, death occurred a	it the time, date ar	nd place, and due to	the cause(s)
To the Ho within 24 To the Fu completel	Ž	29b. Signature and title of certifier	1-0	1	29c. License nu		29d. D	ate signed (Month,	Day, Year)
			Miles, ms		Nas	205	10	ine 4,0	2005
13	1	IN A. Reley	mpleted cause of death (Item	23a) (Type, F	Print) N. Cha	ilos St.	Balt	ine 4, e	2020
	tate	31. Date filed (Month, Day, Year) / JUN 0 7 2005	32. Registrar's Signate	ure					
Regis	trar		Bour 15	brack	<i>P</i>				

		I	Amend Items# 10c,e &f per FH G851 1.6/06 CC Certificate of Death	Mental Hygiene  Reg. No. 2005 18894
	Physicia	n	1. Decedent's Name (First, Middle, Last)	2. Dete of Deeth Month Dey Year 7 3 Am
1	/Medica Examine		46 Fecility Neme (If not institution, give street and number) 4b. City, Town, or	Location of Deeth 4c. County of Death
	LAMINIC		manor care West Road Tou	son Baitmore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hr. Months Deys Hours Mir	
	Director		Usual Residence of Decedent	April 1923 Inargiana
	show	٦	10a. Stete 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 ☐ Yes 212 No
	28a-f	ž	10e. Street end Number 4522 Ridge Rd. Perryl	10g. Citizen of What Country?
	efter death with the Maryland or items 23e or 28e-f show refree must be notified at	Funeral Director	1908 Daletord Rd 21234	USA
	er dea	nue	11. Maritel Stetus 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (1997)	Specify Yes or No- rto Rican, etc.)  14. Race - American Indian, Black, White, etc.
5-0020	hours efter turel', or the			specity: White
2-0	"natural",	Completed by	15. Decedent's Education (Specify only highest grede completed)  16e. Decedent's Usual Occupation (Give kind of work done during most of wo	orking 16b. Kind of Business/Industry
2121	within ene.	dwc	Elementery/Secondary (0-12) College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)	Mechania R.E. Michaels Co
	should be filed within and Mentel Hygiene. marked other than amatic event, the M	Be C	17. Father's Neme (First, Middle, Lest)  18. Mother's Na	ame (First, Middle, Maiden Sumame)
Maryland	ould be Mentel Marked o	0	George S. Brende I Anno	e c. Minkleman
a ¥	C 0 0 0 0	1	19a. Informan' Mame/Relationship (Type, Print)  19b. Mailing Address (Street and Number or F  19c. Mailing Address (Street and Number or F	Rural Route Number, City or Town, State, Zip Code)
ore,	of Health of Health item 27 r other tr	1	20a. Method of Disposition (Name of gemetery, crematory or other place)	Date 20c. Location - City or Town, State
Baltimore	Ling Tell		4 Donation 5 Other (Specify) EVANS Funeral Chape	2005 Forest Hill Mandan
Bai	permit. Per Depertment Important: any Injury o		21. Short and Address of Fifcility F.	ians funeral chapel
		$\dashv$	23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardie shock, or heart failure. List only one cause on each line.	ac or respiratory arrest, Approximate
	Physician		shock, or heart fallure. List only one bause on each line.	Interval Between Onset and Death
	/Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)  e	
		je l	Due to (or es a corpeque) ce ot):	ulmonay direce
V	and transit	Examine	Sequentielly list conditions.  Due to (or es a consequence of):	
,60	be exertician exictan expension of the contract of the contrac	<u>a</u>	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	
_	tificate be ig physicit es the bu	Medical		
Вох	v requires that tha deeth certificate be executed been signed by the ettending physician end should be detached for use es the buriat-transit	Completed by Physician/M	d	
	tha de	ysic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?
	requires that tha been signed by the hould be detach	2		1  Yes 2 No 3 Probably 4 € Unknown
Records,	een sig	Zied		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause
9	2 8 8	E		of death?
tal	ysician: The is certificate he diractor, pega	8	25. Was case referred to medical 26. Place of De	No 1 Yes 2 No
Division of Vital	Physician: rthis certific rel diractor,	0		Home 5 ☐ Residence 6 ☐ Other (Specify)
ono	ding P. h. After t funer		27. Manner of Death Naturel 5 Pending (Month, Dey Year)  28b. Time of Injury 28b. Time of Injury 4 Work?  2 Accident investigation	28d. Describe how injury occurred
Visi	Attending ar death. actor: Afte by the fune		3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Ö	urs afta urs afta rai Dir	5		
	To the Hospital or Attending Ph within 24 hours aftar death. To the Funeral Diractor: After thi completely filled in by the funerel	edical Certification:	29a. Certifier  (Check only one)  29a Certifying Physician: To the best of my knowledge, death occurred at the time, date and plec (Check only one)  2 Medical Examiner: On the basis of examination ind/or investigation, in my opinion, death occurred at the time, date and plec (Check only one)	
	Vithir To th	M	29b. Signature and the of certifier 29c. License number	29d. Date signed (Month, Day, Year)
	1		53395	1613/08
	4		30. Name and advess of person was completed cause of death (Item 23a) (Type, Print)  AShort Joleh yw Fig. 7	Janze 42 2150 A.
A.	State		31. Date filed (Mod ) Phy (Year) 2005 Registrer's Signature	
	Registra	r	The second of the second	

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Registrar

2005

			1 - For State Registrar	State of Marylan		artment of rtificate o		nd Menta	l Hygier Reg.	400	5	188	196
	Physici		1. Decedent's Name <i>(First, Middle, Last</i> <b>Matthew G. Braxton</b>	")				Mor	e of Death oth 1	,	ear	3. Time of 10:15	
	/Medic Examir		4a. Facility Name (If not institution, give	w Road		n/a		Death		4c. County of Ba 1			
	Funeral Director		5. Social Security Number 226-30-9512  Usual Residence of Decedent	7. Age (In yrs. I. 74	Yrs.	If Under 1 Yea Months Day		Min. (Mor	of Birth oth, Day, Ye. - 22 – 1		Birthplace Country) Virg		Foreign
	e Marylanda-ia-f show	ctor	10a. State 10b. County  Md Baltimo		, Town or Lo n /							Inside Cit	
	th with th	al Director	10e. Street and Number 6805 Fox Meado	w Road		10f. Zip Code 2 <b>1</b> 2			10g.	Citizen of Wha	at Country?	?	
9036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show disal Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  XXVIdowed 4 Divorced	12. Was Decedent Ever in U.s Amjed Forces? A(7)Yes 2 □ No If Yes, Give Year or Dates: 1951	81	Was Decedent of f Yes, specify Cu I ☐ Yes 2 N		in? (Specify Yes Puerto Rican, e	or No- tc.)	Specify:	American I White, etc. African	can-	
21215-0036	d within 72 h jiene. r than "natu the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed)  College (1-4or 5+) 5 +	(Give . life. L	lent's Usual Occ kind of work dor DO NOT use reti pler C	ne during most red)			Kind of Busin	ness/Indust	try	
Maryland ?	2 should be filed and Mental Hyg Is marked othe sumatic event,	To Be C	17. Father's Name (First, Middle, Last) James A. Braxt	on				s Name (First, 1 ggie He		len Sumame)			
Baltimore, Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Del artment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at one.	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Caren Braxton-Woods/Daughter 8500 Valley Hill Ct., Randallsto  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State, Caren Braxton-Woods/Daughter 8500 Valley Hill Ct., Randallsto  20c. Location - City or Cemetery, crematory or other place)  20c. Location - City or Town, State, Caren Braxton-Woods/Daughter 8500 Valley Hill Ct., Randallsto  20c. Location - City or Town, State, Caren Braxton-Woods/Daughter 8500 Valley Hill Ct., Randallsto  20c. Location - City or Town, State, Caren Braxton-Woods/Daughter 8500 Valley Hill Ct., Randallsto  20c. Location - City or Town, State, Caren Braxton-Woods/Daughter 8500 Valley Hill Ct., Randallsto  20c. Location - City or Town, State, Caren Braxton-Woods/Daughter 8500 Valley Hill Ct., Randallsto  20c. Location - City or Company										Md State d. Co.	
	Priysician /Medical	9200 Liberty Rd. Randallst 234. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.									Ap Inte	211 proximate erval Betw set and D	veen
8760,	Examiner and transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to the a consequence.  Due to the a consequence.  Due to the accommodity.	ence of):	te a	ndur	osula	- du	reci	γ γ	gan an	1
.O. Box 6	The law requires that the death certific ate has been signed by the attending page 2 should be detached to use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	icy			23d. Date of delivery Month Day Year						
<u>а</u>	w requires that been signed b should be deta	by	( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )							23e. Did tobacco use contribute to the cause  1 Yes 2 No 3 Probably 4			eath?
Il Records,	The law recate has been page 2 sho	Completed								prior	e autopsy to completh?	tion of ca	
f Vital	yaician: Th	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	26. Place of Death  lospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hom								
Division of	To the Hospital or Attending Physician: whithin 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director;	Certification:	The state of the s							jury occurred			
N N	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · At hor building, etc. (Specify)	ne, farm, stre	eet, factory, office	9		tion (Street or Town, Sta	and Number o ate)	r Rural Ro	ute Numb	ier,
	the Hosp in 24 hou the Fune ipletely fil	Medical	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sician: To the best of my know ner: On the basis of examinati and manner stated.	riedge, death on and/or inv	occurred at the estigation, in my	time, date and opinion, death	place, and due occurred at the	time, date a	(s) and manne nd place, and	or as stated due to the	cause(s)	
	To To	2	29b. Signature and title of certifier  Ducul  V	glen MD		29c. Licer	7263	94		CI3/O	_	Year)	
	12	Ī	30. Name and address of person who co	my ST BA	23a) (Type, F	Print) M ()	,51,	204					
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 7 2005	Registrar's Signatu	Special	K							

			1 - For State Registrar	State of Maryla				Mental Hy	/giene 05	18897
	Physic /Medi Examii	cal	1. Decedent's Name (First, Middle, Las PAT R ( C I A 4a. Facility Name (If not institution, give		BE	RNSTE 4b. City, Town	E/N, or Location of Dea	2. Date of Do JUNE	Day Yes	18 43 M
	Funeral Director		5. Social Security Number 6. Se	okins Hospi ex 7. Age (in y)	rs. last birthday) Yrs.	Towns A.C. A.		. (Month. D		ORE CITY irithplace (State or Foreign Country) PA
	he Maryland :8a-f show	Director	10a. State 10b. County ANNE A		City, Town or Lo	IIE				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
10	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It and Mental Hygiene. It Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Exameratinust he notified at	Funeral Dire	10e. Street and Number  1426 RAWE DR.  11. Marital Status  1 □ Never Married 2 □ Married	12. Was Decedent Ever in Armed Forces?	U.S. 13.	10f. Zip Code 21061 Was Decedent of If Yes, specify Cu	f Hispanic Origin? ( uban, Mexican, Pue	Specify Yes or Norto Rican, etc.)	USA 14. Race - An Black, Wi	nerican Indian,
Baltimore, Maryland 21215-0036	nin 72 hours a' in "natural', oi Medical Exam	Completed by I	3XXVidowed 4 □ Divorced  15. Decedent's Ed (Specify only highest grade)  Elementary/Secondary (0-12)	de completed)	16a, Dece	1 Yes 2X N  dent's Usual Occ kind of work don  DO NOT use reti		orking	Specify:WH	
land 212	ould be filed within Mental Hygiene. arked other than " atic evant, "to Me	To Be Com	17. Father's Name (First, Middle, Last) EARL DAUD	College (1-4or 5+)	НОМЕ	MAKER		me (First, Middle	OWN HOME , Maiden Sumame)	
re, Mary	1 an Heal em 2 ther		19a. Informant's Name/Relationship (TDENISE WEATHERBEE 20a. Method of Disposition	/ DAUGHTER	. Place of Dispo	915 MEAI	DOWGATE CO		NDSOR MILL  20c. Location - City of	, MD 21244
Baltimo	permit. Pages Department of I Important: If its any injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of June al Service Licens	CH	ESAPEAK	natory or other p  E CREMAT  Name and Add  NGLETON	CION 20	005	STEVENSVIL	LE, MD
	Physician		23a. Part1. Enter the disease, or comp shook, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the de one cause on each line.	ath. Do not ent	er the mode of d	ying, such as cardia	CLEN BU c or respiratory a	RNIE, MD 2	Approximate Interval Between Onset and Death IDMINUTES
8760,	/Medical Examiner ohysician and the burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ACUTE  Due to (or as a conse  C. Due to (or as a conse  Due to (or as a conse  d.	equence of):	CARPI	BRILAT	JRC7701	υ	22 Hours
P.O. Box 68	that the death certitics ed by the attending pr detached tor use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Wo 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnan	су		23d. Date of di Month	alivery Day Year
	requires een sign hould be	by	Part II. Other significant conditions co	ntributing to death but not re	esulting in the ur	nderlying cause g	oven in Part I.	23e. Did t	obacco use contribute Yes 2 2 No 3 ☐ F	to the cause of death?  Probably 4 Unknown
ital Rec	The la ate has page 2	e Completed	25. Was case referred to medical				26 Place of De	24a. Was autor perfo  1  Yes  ath (Check only of	osy prior to death? death? 2 d No 1 □ Ye	autopsy findings available completion of cause of
Division of Vital Records,	Attending Physician: It death. actor: After this certific. by the funeral director,	ation: To B	examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 [ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inji	ther: 4 \sum Nursing F	lome 5 ☐ Resid	dence 6 Other (Sp	ecify)
DIVis	i Dir	ai Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Specialistician: To the best of my kn	owledge death	occurred at the	time date and place	City or Tox	cause(s) and manner a	s etated
	To the Hospital within 24 hours a To the Funeral I completely tilled	Medical	(Check only one)  2 Medical Exami  29b. Signature and title of certifier	ner: On the basis of examinand manner stated.	nation and/or inv	estigation, in my	opinion, death occu	irred at the time,	date and place, and du	e to the cause(s)
(	0		30. Name and address of person who co	ompleted cause of death (Ite	om 23a) (Type, F	Print)	H WIFE S		JUNE 2	YLAND ZIZST
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 7 200	32 Registrar's Sign	nature &	de)		- 1011	,,,,,,	

		,	1 - For State Registrer		f Marylar		-	of H		_	ental Hyg	iene	1005	18898
ı	Physici /Medic		1. Decedent's Name (First, Middle, EDNA	BALA	Z						2. Date of Dea Month	th Day	9 20	3. Time of Death
	Examir	_	4a. Facility Name (If not institution,	give street and nur	nber)		4b. City, T	own, or	Location o	of Death			County of D	
	MI		HARBOR HOSPITAL		~ 4 //-	t	I	OKLY	N If Under 2	DA Usa				ORE CITY
	Funeral Director		5. Social Security Number 216-24-2845  Usual Residence of Decedent	. Sex 1 ☐ M 2 [X] F	7. Age (In yrs.	75 Yrs.	If Under 1 Months	Days	Hours	Min.	8. Date of Birth (Month, Day 08/06/	Year) 1929	9.	Birthplace (State or Foreign Country) PA
	Maryland -f show lied at	tor	10a. State 10b. County MD ANNE AR	UNDEL	j	ty, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 XNo
	h the	Irec	10e. Street and Number		<u> </u>		10f. Zip (	Code			1	0g. Citi	zen of What	Country?
	238 c	alD	548 SHIPLEY ROA	D			21	090					USA	
980	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-1 show or other freumatic event, the Wedred Exam partment to Indiffed at	by Funeral Director	11. Marital Status  1 Never Married 2XXMarried 3 Widowed 4 Divorced	Armed Fo	2 ሺ No e	1	Was Decede If Yes, speci 1 Yes 2	**	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		14. Race - A Black, W Specify:	
21215-0036	e filed within 72 h al Hygiene. I other than "netu vent, I verical	Completed	15. Decedent's (Specify only highest to Elementary/Secondary (0-12)		-4or 5+)	(Give	dent's Usual kind of work DO NOT use	done d retired)	ition luring most	of workir	ng		nd of Busine	
2	filed v Hygie other t	CO	17. Father's Name (First, Middle, La	st)		SEAM	ISTRES	5	18. Mothe	r's Name	(First, Middle, I		AILOR:	LNG
Maryland	should be and Mental marked o	To Be	CHARLES BERQUIS	T						JESS:	IE WORK	OWSK	I	
	1 and 2 sho Health and Iem 27 is m		19a. Informant's Name/Relationship MR. GUSTAVE BAI		BAND						HICUM,		Town, State 21090	. , ,
ore	Pages 1 nent of He int: If iten		20a. Method of Disposition		State	Place of Dispo cemetery, crer	natory or oth	ner place						or Town, State
Baltimore,	permit. Pages 1 a Department of Hes Importent: If item any injury or othe		*4 □ Donation 5 □ Other (Spe 21. Signature of Fundamental Service Con-	The state of the s	MEA		. Name and	Addres	s of Facility	SIN	GLETON	FUN		HOME
	89 E 8 8	10 %	(hico	elly.	mass						GLEN F		IE, MI	<del></del>
	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause on e	ach line.	uence of):		_				əst, 		Approximate Interval Between Onset and Death Sudden
	Examiner	0	Sequentially list conditions,	b	IPER	TEN	710.	$\sim$						
o,	icate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any leading to mm dials cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (	ABE or as a conseq	TE suence of):	MC	ELL	-17	25				
8760,	physic physic the bu	dica		d										
P.O. Box 6	The law requires that the death certificate be executed tie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 mooths? 1 □ Yes 2 □ No 9 □ Unknown		rth 2 ☐ Feta ant at time of d	I death 3	Ectopic pre Other (spe					2	3d. Date of o	delivery Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions	contributing to de	ath but not res	ulting in the ur	nderlying car	use give	n in Part I.			acco us		to the cause of death?
Division of Vital Records,		Completed									24a. Was a autops perform	y ned?/		
/ita	cien: entific actor,	Be	25. Was case referred to medical examiner?			/					Check onl on	_		
nof	Attending Physicien: r death. ector: After this certifics by the funeral director, g	on: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date o		ER/Outpatien 28b. Time of Injury		c. Injury Work			e 5 Reside 8d. Describe ho			pecify)
Divisio	To the Hospital or Attending Physicien: whin 24 hours after deals. To the Funerel Director: After this certific completely filled in by the funeral director,	ertification:	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place	of Injury - At h	ome, farm, stre y)	M 1 ☐ Yes 2 ☐ No  arm, street, factory, office  28f. Location (Street and Number or Rural Route Nu City or Town, State)					Rural Route Number,		
_	To the Hospital or A within 24 hours after To the Funerel Dire completely filled in b.	edical Ce	29a. Certifier 1 Certifying I (Check only one) 2 Medicel Ex	Physicien: To the eminer: On the ba and mann	sis of examina	wledge, death tion and/or inv	occurred at vestigation, i	t the time	e, date and inion, deat	d place, and due to the cause(s) and manner as state th occurred at the time, date and place, and due to the				as stated. ue to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and maill	o. stateu.				number		25	d. Date	signed (Mo	nth, Day, Year)
	7		19200	wnd	my		1	)4i	49	1		05	/3//	nth, Day, Year)
8	U		30. Name and address of person wh						Rona	Chir	this m	1	102	1090
	Sta Registr	A	31. Date filed (Month, Day, Year)	2005	istrar's Signa	ture	reeles							

Please	Type or	Print in	Black	Indelible Ink.	Ensure All	Copies	Are Legible.
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			1 - For State Registrar	State of	Maryland / Depa	artment of H			iene	10000				
			1. Decedent's Name (First, Middle, Last	)				2. Date of Death Month	h Day Yeer	3. Time of Death				
	Physici /Medid		Ella Mae Boyd					June 4, 2		12:10 P M				
	Examin		4a. Facility Name (If not institution, give	street and numb	er)	4b. City, Town, or	Location of	Death	4c. County of Death	1				
			Stella Maris Hospice			Lutherv								
	Funeral		5. Social Security Number 6. Se	x 7. □M 2 <b>X</b> F	Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, Day,	Year) 9. Birth	nplace (State or Foreign untry)				
	Director		217-22-7577 Usual Residence of Decedent		76 Yrs.			08-26-1928	8 South	Carolina				
	and w		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits				
	f sho	ō	MD D-1+:-			T				1 <b>XX</b> Yes 2 ☐ No				
	the 1	Director	MD Baltin  10e. Street and Number	bre		Towson 10f. Zip Code		11	0g. Citizen of What Co	untry?				
	3a or	٥	500 Virginia Towers Ap	+ 1503		2128	9		USA					
	ms 2	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S. 13.			n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Amer					
ယ	or Ite	Ē	1 Never Married 2 Married	Armed Force	XXNo	1 Tes, specify Cuba 1 ☐ Yes 2 💢 No	Specify:	Puerto Rican, etc.)	Black, White	3, OC.				
8	hours after death with the Maryland tural', or Items 23a or 28a-f show al Examiner must be collined at	l by	3 Widowed 4 □ Divorced	If Yes, Give Year or Date	es:	10163 244110	ороспу.		Specify: Bla	ick				
5	72 na	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most o	of working	16b. Kind of Business/	ndustry				
7	within ene. than "	mpi	Elementary/Secondary (0-12)	College (1-4	or 5+)		)	<b>%</b>	17 1 - 1	G.				
2	e filed v Il Hygie other t		8 17. Father's Name (First, Middle, Last)			Nurse	18 Mother	s Name (First, Middle, A		n Care				
and	0 G 5 0	Be	York Brown					Ann Brown	···,					
Ž	should be nd Mental markad o umatic eve	2	19a. Informant's Name/Relationship (7	voe. Print)	19b. Maili	na Address (Street a		or Rural Route Number,	, City or Town, State, 2	lip Code)				
Maryland 21215-0036	d 2 sho th and t7 Is m traum		Clarence Cheeks Jr.					1503 Towson,	•					
	s 1 and 2 should if Health and Mer itam 27 Is marks other traumatic		20a. Method of Disposition			osition (Name of matory or other place		100	20c. Location - City or	Town, State				
OL	Ø D L		1 \$\infty\$ Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify		are i	urch Cemete		-09-2005	Chester, Sou	th Carolina				
Baltimore,			21. Signature of Funeral Service Ligen			2. Name and Addres	-	0, 2003	onobcoz, boo	CIT OCIZOTZIA				
ñ	permit. Departr Importa any inji		Lumela fo	(_مور	Wy	lie Funeral	Home 6	38 N. Gilmor S	St. Balto, MD	21217				
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that cau	ised the death. Do not en	ter the mode of dyin	g, such as c	ardiac or respiratory arre	est,	Approximate Interval Between				
	Priysician		Immediate Cause (Final disease or condition		EATIC CANCER	•				Onset and Death				
	/Medical		resulting in death)  a											
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	p ii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence of):									
	and and I-tran	Examine	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):											
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687	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical		d										
×	leath certifica attending ph I for use as th	/Me	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy				23d. Date of deli	ivery				
Вох	eath atter	ciar	in the past 12 months?			□Ectopic pregnancy □ Other (specify)			Month	Day Year				
0	at the de by the a	hysi	9 Unknown	9□ Unknov	m									
<b>Q</b>	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions of	ontributing to dea	th but not resulting in the u	inderlying cause give	en in Part I.	23a. Did tob	bacco use contribute to	the cause of death?				
Records,	w require been sig should b							1 🗆 Ye	es 2⊡No 3⊡Pr	obabiy 4 YUnknown				
000	aw re	Completed						24a. Was a autops		topsy findings available completion of cause of				
Ä	0 - 0	Eo						perform	med?   death?	2□ No				
Vital		a	25. Was case referred to medical				26. Place	of Death (Check only on						
<b>V</b>	gg. ₹	To B	examiner? 1 ☐ Yes 2 <b>X</b> No	Hospital: 1 ☐ In	patient 2 ER/Outpatie	nt 3 DOA Oth	er: 4 🗆 Nur:	sing Home 5 Reside	ence 6 X Other (Spec	eify) HOSPICE				
n of	ding Ph h. Atter th funeral		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of (Month	Injury 28b. Time of Injury	Wor			ow injury occurred					
sio	Attending r death. actor: After by the fune	catio	2 ☐ Accident investigation				Yes 2 N							
Division	or Attendated after death	Certification:	3 Suicide 6 Could not be determined	288. Place C	f Injury · At home, farm, st g, etc. <i>(Specify)</i>	reet, factory, office		28f. Location (St City or Town	treet and Number or Ru n, State)	Irai Houte Number,				
	urs al urs al aral D		On One William Share Sha	velsion. To the b	and of my languages does	th accurred at the time	us date and	lalace and due to the o	auga(a) and manner as	stated				
	To the Hospital or A within 24 hours after To tha Funaral Dira completely filled in b	edicai	29a. Certifier (Check only one)  1X Certifying Ph 2 Medical Exam	ysician: 10 the bas and manne	est of my knowledge, dea sis of examination and/or it ar stated	nvestigation, in my o	ne, date and pinion, death	n occurred at the time, d	ause(s) and manner as late and place, and due	to the cause(s)				
	o the ithin 3	Mec	29b. Signature and title of certifier	7	statos.	29c. Licens	e number	2	9d. Date signed (Mont	h, Day, Year)				
	F 3 F 8													
7	1 X		30. Name and address of person who	completed cause	of death (Item 23a) (Type	, Print)			6/6/					
	1		DD TADIO MAHMOO	2300	DIII ANEV VATI	ר מקיעו	[IMONI	UM, MD 2109	3					
	St	ate	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signature	U								
	Regist	rar	HIN A 7 2005	Herens	Dr Harman									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 2005 Patricia Mary Burton June 3 /Medical 1:00 p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Rehab. & Nursing Center Burtonsville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2 🕏 F 577-54-4103 Director 64 Dec. 2, 1940 Washington, DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. snt: If item 27 ia marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ral', or items 23a or 28a-f shov Examiner roust be notified at Director 1 ☐ Yes 2 ☐ No Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5296 Sands Road 20711 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X X o If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXVo Specify: White 3 ☐ Widowed 4 ☐ Divorced Specify: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature any injury or other traumatic avent, It a Madical pine. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Aide P.G. County 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Joseph Matthews ပ္ Mary Garner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5296 Sands Road, Lothian, MD 20711 John H. Burton (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 6/6/2005 Baltimore, MD 21. Signature of Funeral Service licer 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CancinomA LARYNX **Physician** disease or condition resulting in death) 09/200 /Medical Due to (or as a consequence of): Examiner merasturic disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit To allove Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, pulmony disease Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes Completed 2 No 3 Probably 4 Unknown this certificate has been al director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Certification: To 1 Yes 2 Mo Cther: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 Tes 2 No s after death 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) pelluga 6. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Upper Marlboro Champaloup 6 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 7 2005 Registrar

			1 - For State Ragistrar	State of		nd / Depa		t of H	lealth a	and N	n copies dental Hy		005	)	1891	01
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	Funeral			6. Sex 7 1KD M 2 ☐ F		last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	rth ay, Year)	9	. Birthp	place (State of	r Foreign
	Director		523-36-8635	TEM ZOF		// Yrs.					Feb. 6	, 19	28 ] ]	New	Jerse	У
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						<del> </del>	1	0d. Inside Cit	tv Limits
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	with Sa or	Ö		) <b></b>				208	252			-	ted St		,	
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03	ai', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Da	e WWII		1 ☐ Yes 2	2XI No	Specify:				Specify:	Wh	ite	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-1 show ite Medicul Exal' it at mast be putified at	Completed by Funeral Director	15. Decedent's (Specify only highest	s Education		16a. Dece	dent's Usua	l Occup	ation	at of work	tina	16b. K	and of Busin	ness/Inc	dustry	
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Maryland	de mi		19a. Informant's Name/Relationsh								al Route Numb					
	and lealth m 27 her ti		Clark S. Bensen	Son	700						yton, M	_				
ore	iges 1 it of H if ite or otl		20a. Method of Disposition  1   Burial 2   Cremation	3 □Removal from S	State Moi	Place of Dispo cemetery, crei ntgomen	~ 37		,		Date		ocation - Ci	•		
Ë	mit. Pag partment cortant: injury e		' 4 □ Donation 5 □ Other (Sp	ecify)	1107	Crema	toriu	m, I	nc.	JUNE	4,2005	Beth	esda,	Ma	ryland	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra once.		21. Signature of Funeral Service L	icensee)	MO138	16 Ro	2. Name an Ckvil ckvil	d Addres le, le.	is of Facili Inc. Marv	y Rob 300 Land	West M	Pum lont 2805	phrey omery	Fun	neral H enue	lome/
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7	/Medical		resulting in death)	a	or as a consec	quence of):								- 1	23 Day	S
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39	ng pt	Completed by Physician/Med	IF FEMALE:													
Box	th ce tendi	an/I	23b. Was decedent pregnant	23c. If yes, outc	come of pregn rth 2 Peta		∃Ectopic pr	egnancy					23d. Date of			ear
.O.	e dea	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregna	ant at time of o	death 5	Other (sp	ecify)					Month		Day Y	eat
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u u	ng P	on:	27. Manner of Death 1	28a. Date of (Month)	f Injury n, Day Year)	28b. Time of Injury		8c. Injun Worl			28d. Describe	how inju	ry occurred			
sio	Attending r death. ector: After by the fune	cati	2 Accident investigation in Suicide 6 Could no	ation of he			М		Yes 2□	No						
Division	or At ifter d Direct in by	Certification:	4 Homicide determin	and 289 Place	of Injury - At h g, etc. (Speci	iome, farm, str <i>fy)</i>	eet, factory	, office			28f. Location City or To			or Rura	il Route Numb	5⊖r,
	urs a urs a ural D															
	To the Hospital or Attending Physician: The lav within 24 hours after death.  To the Funeral Director: After this certificate has completely tilled in by the funeral director, page 2	Medical		Physician: To the back eminer: On the back and manner	sis of examina											i
	To the To the Comp	Me	29b. Signature and title of certifier				29c	License	number			29d. Da	te signed (/	Month,	Day, Year)	
			I the All	w?				D18	726			Jun	e 2, 2	2005	5	
	1241		30. Name and address of person w	no completed cause	of death (Ite	m 23a) (Type,	Print)									
	1 0		Arthur Schoengo					Lp D	rive,	01r	ney, Mar	ry1a	nd 208	332		
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			1 - For State Registrar		f Maryland	/ Depa		t of H	ealth a		lental Hy		9	13	903
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	/Medic		Mary	Amanda	Black						June	3	2005	2:40	Ам
}	Examin	er	4a. Facility Name (If not institution						Location of				County of Death		
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	Funeral Director		5. Social Security Number 579–18–9227	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. last 86	Yrs.	If Under Months	Days	If Under: Hours	Min.	8. Date of Bin (Month, Da July 7,	v. Year)	Cou	place (State intry) n Caro	_
	pug 🗼		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or L	ocation							10d. Inside C	ity Limite
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	the N	ect	10e. Street and Number	ELC	Lust	y	10f. Zip	Cada				10a Citia	ten of What Cou		
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(0	r Her	Fun	1 ☐ Never Married 2 ☐ Marr	ied Armed For	rces? 2 🔼 No	- 1				, Puerto	ecify Yes or No Rican, etc.)	i	Black, White	etc.	
ğ	ral', o	by	3 Nidowed 4 Divorced	If Yes, Giv Year or Da	e ates:		1 🗌 Yes	2 <u>X</u> J No	Specify:				Specify: Wh:	ite	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show he Medical Examinar must be notified at	Completed	15. Deceden	t's Education st grade completed)	1	6a. Dece	dent's Usua kind of wo DO NOT us	al Occupa	ation furing most	of worki	na	16b. Kin	d of Business/Ir	ndustry	
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Z	thould Me mark mark	2	19a. Informant's Name/Relations			9b. Maili	na Address					er City or	Town, State, Zij	n Code)	
<u>≅</u>	od 2 state are trau		Joan L. Sampson		1								and 206		
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		20a. Method of Disposition		20b. Place	of Dispo	osition (Nar matory or o	ne of	- !		ate		ation - City or T		
Ë	Page ent o nt: If ry or		1 🕅 Burial 2 □ Cremation  '4 □ Donation 5 □ Other (S				Memo rk			ıne 7	, 2005		yland		
Baltimore,	permit. Departm Importe eny inju		21. Signature of Funeral Service	Ligensee		22	2. Name an	d Addres	s of Facility	Robe	rţ A. I	umph	rev Fune	eral H	ome
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Г			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca only one cause on ea	aused the death. [ ach line.									Approximati Interval Bet	te tween
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В	- Adminion	<u>.</u>	Sequentially list conditions,	b. La	ng cord	na	y A	yes	y d	150	ase		_		
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	xecul and al-tra	xan	Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consequen	ce of):									
8760,	cate be executed ohysician and the burial-transit	icai E													
9	ifficat g phy as th														
Вох	death certificat e attending phy od for use as th	N/N	IF FEMALE: 23b. Was decedent pregnant		come of pregnancy irth 2 Petal de		⊒Ectopic pr	9002001				2	3d. Date of deliv	ery	
. B	0 0 0	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of death		Other (sp						Month	Day	Year
P.O.	law requires that the desas been signed by the a	Physician/Med	9 Unknown								1				
	res th	by	Part II. Dther significant condition									obaccous ′es 2□	se contribute to t No 3 ☐ Prol		ueath? Unknown
Orc	v requir been si should	eted	apperfere	ion, co	repray	·	scu	ar							
Records,	ne faw has t ge 2 s	Completed	disease,	hyperlip	n denu	a					24a. Was autop		24b. Were auto prior to co death?	ppsy findings impletion of c	available ause of
al	T+ ate pa			U ·							1 Yes	\$25 No	1 Yes	2 No	
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital:	×			Othe	A CT		(Check only o				
of	Phys rrthis aral di	$\vdash$	1 ☐ Yes ② No  27. Manner of Death	28a. Date o	of Injury 28	Outpatier  b. Time o		8c. Injury Work	4   1401	-	ne 5 ∐ Resid 28d. Describe h		Other (Special	(y)	
lon	Attending I ar death. ector: After by the funer	tior	1 Natural 5 Pendin 2 Accident investi	g (Monti	h, Day Year)	Injury	М		:? /es 2 □ N	No					
Division	Attendi er death. ector: A by the fu	ific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 200. Place	of Injury - At home	, farm, str	eet, factory	, office		2	28f. Location (S City or Tou		Number or Run	al Route Num	iber,
	tal or s afte al Dir ed in	Certification:	4 LI Nomicida	Duligir	ng, etc. (Specify)						City of You	m, State)			
	lospi hour uner	edical	29a. Certifier 1 Certifyir (Check only 2 Medical	ng Physician: To the Examiner: On the ba	best of my knowled	dge, deat	h occurred	at the tim	e, date and	d place, a	and due to the	cause(s) a	and manner as s	tated.	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medi	One)	and mann	er stated.										
	To Too	-	29b. Signature and title of certifie				290	. License	י ממייי א			zsu. Date	signed (Month,	uay, rear)	
•	1		Much	M MI)	a of docth //	2) (7	Deige	058	572		,	Jus	e 4th.	2005	
	b		30. Name and address of person	who completed cause	or death (item 23	a) (Type,	101.	C.i.	6 210	0.	400 G -	land d	4 110	201.70	-
	Sta	te	31. Date filed (Month, Day, Year)	\$2. Re	egistrar's Signature	pi ju	100	Jul!	1 210	_rn	nce prec	un U	-, mu	20018	
	Registr	-	JUN 0 7 2	1005 Elect	e of death (Item 23	6									

Prysician   Frederick   A. Brown   Substitution   Duration   Dur			Stete Registrar	te of Maryland / Depa	artment of Health and I	Mental Hygi	_	18901
Hospice of Baltimore Silchrist Center  Towson  Figure 1 10 10 10 10 10 10 10 10 10 10 10 10 1	/Medi	cal				June 0	2 2005	3. Time of Death 7:55 A
The part of the		ner	Hospice of Baltimore G	ilchrist Center	Towson  If Under 1 Year   If Under 24 Hrs.		Baltimore	place (State or Forei
Baltimore County Principal  18. Mother's Name (First, Middle, Last)  Frederick Thomas Brown  Is Mother's Name (First, Middle, Last)  Frederick Thomas Brown  Is Mother's Name (First, Middle, Last)  Frederick Thomas Brown  Is Mother's Name (First, Middle, Last)  Frederick Thomas Brown  Is Mother's Name (First, Middle, Mailton Sumanus)  Frederick Thomas Brown  Is Mother's Name (First, Middle, Mailton Sumanus)  Frederick Thomas Brown  Is Mother's Name (First, Middle, Mailton Sumanus)  Frederick Thomas Brown  Is Mother's Name (First, Middle, Mailton Sumanus)  Frederick Thomas Brown  Is Mother's Name (First, Middle, Mailton Sumanus)  Frederick Thomas Brown  Is Mother's Name (First, Middle, Mailton Sumanus)  Frederick Thomas Brown  Is Mother's Name (First, Middle, Mailton Sumanus)  Frederick Thomas Brown  Is Mother's Name (First, Middle, Mailton Sumanus)  Frederick Thomas Brown  Is Mother's Name (First, Middle, Mailton Sumanus)  Frederick Thomas Brown  Is Mother's Name (First, Middle, Mailton Sumanus)  Frederick Thomas Brown  Is Mother's Name (First, Middle, Mailton Sumanus)  Frederick Thomas Brown  Is Mother's Name (First, Middle, Mailton Sumanus)  Frederick Thomas Brown  Is Mother's Name (First, Middle, Mailton Sumanus)  Frederick Thomas Brown  Is Mother's Name (First, Middle, Mailton Sumanus)  Frederick Thomas Brown  Is Mother's Name (First, Middle, Mailton Sumanus)  Frederick Thomas Brown  Is Mother's Name (First, Middle, Mailton Sumanus)  Frederick Thomas Brown  Is Mother's Name (First, Middle, Mailton Sumanus)  Frederick Thomas Brown  Is Mother's Name (First, Middle, Mailton Sumanus)  Frederick Thomas Brown  Is Mother's Name (First, Middle, Mailton Sumanus)  Frederick Thomas Brown  Is Mother's Name (First, Middle, Mailton Sumanus)  Frederick Thomas Brown  Is Mother's Name (First, Middle, Mailton Sumanus)  Frederick Thomas Brown  Is Mother's Name (First, Middle, Mailton Sumanus)  Frederick Thomas Brown  Is Mother's Name (First, Middle, Mailton Sumanus)  Frederick Thomas Brown  Is Mother's Name (First, Middle, Mai	Director		Usual Residence of Decedent	70		Nov. 20,		
Baltimore County Principal  18. Monther's Name (First, Middle, Last)  18. Monther's Name (First, Middle, Last)  18. Monther's Name (First, Middle, Last)  18. Monther's Name (First, Middle, Last)  18. Monther's Name (First, Middle, Last)  18. Monther's Name (First, Middle, Last)  18. Monther's Name (First, Middle, Last)  18. Monther's Name (First, Middle, Last)  18. Monther's Name (First, Middle, Middle, Last)  18. Monther's Name (First, Middle, Middle, Last)  18. Monther's Name (First, Middle, Middle, Last)  18. Monther's Name (First, Middle, Middle, Last)  18. Monther's Name (First, Middle, Middle, Last)  18. Monther's Name (First, Middle, Middle, Last)  18. Monther's Name (First, Middle, Middle, Last)  18. Monther's Name (First, Middle, Middle, Last)  18. Monther's Name (First, Middle, Middle, Last)  18. Monther's Name (First, Middle, Middle, Last)  18. Monther's Name (First, Middle, Middle, Last)  18. Monther's Name (First, Middle, Middle, Last)  18. Monther's Name (First, Middle, Middle, Last)  18. Monther's Name (First, Middle, Last)  18. Monther's Name (First, Middle, Middle, Last)  18. Monther's Name (First, Middle, Middle, Last)  18. Monther's Name (First, Middle, Middle, Last)  18. Monther's Name (First, Middle, Middle, Last)  18. Monther's Name (First, Middle, Middle, Last)  18. Mailing Address's (Street and Munther or Rhumber Cort Runther, City or Town, State, Exp Code)  20. Part of Middle, Last)  21. Sponiture of Middle, Last)  22. Name and Address's (Street and Munther or Rhumber Cort Runther, City or Town, State)  22. Name and Address's (Street and Munther or Rhumber Cort Runther, City or Town, State)  18. Mailing Address's (Street and Munther or Rhumber Cort Runther, City or Town, State)  22. Name and Address's (Street and Munther or Rhumber Cort Runther, City or Town, State)  22. Name and Address's (Street and Munther or Rhumber Cort Runther, City or Town, State)  22. Name and Address's (Street and Munther or Rhumber Cort Runther, City or Town, State)  22. Name and Address's (Street and Munther	the Maryl r 28a-f sho	rector	MD Baltimore			100		1 ☐ Yes 2 ☐XN
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Bernentan Secondary (6.12) College (1-40.5+) Principal 18. Mosther's Name (First, Medice), Melany Sumanus) Frederick Thomas Brown Frederick Thomas Brown Frederick Thomas Brown Frederick Thomas Brown Frederick Thomas Brown Frederick Thomas Strown Mary Lou Brown / wife  200. Reuter Road; Timonium, MD 21093  200. Method of Disposition (Figure of Disposition) Mary Lou Brown / wife  200. Method of Disposition (Figure of Disposition) Mary Lou Brown / wife  200. Method of Disposition (Figure of Disposition) Mary Lou Brown / wife  200. Method of Disposition (Figure of Disposition) Mary Lou Brown / wife  200. Method of Disposition (Figure of Disposition) Mary Lou Brown / wife  200. Method of Disposition (Figure of Disposition) Mary Lou Brown / wife  200. Method of Disposition (Figure of Disposition) Mary Lou Brown / wife  200. Method of Disposition (Figure of Disposition) Mary Lou Brown / wife  200. Method of Disposition (Figure of Disposition) Mary Lou Brown / wife  200. Method of Disposition (Figure of Disposition) Mary Lou Brown / wife  200. Method of Disposition (Figure of Disposition) Mary Lou Brown / wife  200. Location - City or Town, State, Zip Code)  201. Location - City or Town, State, Zip Code)  202. Location - City or Town, State, Zip Code)  203. Method of Disposition (Figure of Disposition) Mary Location - City or Town, State, Zip Code)  204. Location - City or Town, State, Zip Code)  205. Place of Disposition (Figure of Disposition) Mary Location - City or Town, State, Zip Code)  206. Location - City or Town, State, Zip Code)  207. Place of Disposition (Figure of Disposition) Mary Location - City or Town, State, Zip Code)  208. Location - City or Town, State, Zip Code)  209. Location - City or Town, State, Zip Code)  209. Location - City or Town, State, Zip Code  209. Location - City or Town, State, Zip Code  209. Location - City or Town, State, Zip Code  209. Location - City or Town, State, Zip Code  209. Location - City or Town, State, Zip Code  209. Location - City or Town, State, Zip Code  209. Locatio	ours after dea	by	1 Never Married 2 Married 1 If Ye	Yes 2 (A) NO es, Give			14. Race - Americ Black, White,	etc.
20a. Method of Disposition   D	C 2 3	ompleted	(Specify only highest grade complete Elementary/Secondary (0-12)  Collination	eted) (Give in life. L	kind of work done during most of wor DO NOT use retired)	Ba	ib. Kind of Business/Inc altimore Co	dustry
20a. Membed of Disposition   Cheer (Speedy)   Date   20b. Please of Control Place   Date   20b. Location   Chry or Town, State   Chr	uld be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last)	1111101	18. Mother's Nam	ne (First, Middle, Ma		015
A Donation A Cother (Specify)  21. Signature of Pinnanishvice Usington  22. Name and Address of Facility  Ruck Towson Furneral Home  1050 York Road  Towson, MD 21204  Ruck Towson Furneral Home  22. Name and Address of Facility  Ruck Towson Furneral Home  23. Part I. Enter the desage, or complications the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Immediate Cause (Final Interval Belly Onset and Diversity of Port And Interval Belly Onset and Diversity of Po				ife 2102	Reuter Road; Timo	ral Route Number, C Onium, MD	City or Town, State, Zip 21093	Code)
23a Parti. Enter the disease, or complications than sharpsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Sequentially list conditions, and yieading to minediate clause (Pinal death and yieading to minediate clause (Pinal death and yieading to minediate clause (Pinal death and yieading to minediate clause (Pinal death and yieading to minediate clause (Pinal death and yieading to minediate clause (Pinal death and yieading to minediate clause (Pinal death and yieading to minediate clause (Pinal death and yieading to minediate clause) (Pinal deat	Pages 1 ment of He ent; ff iten ury or oth		1 X Burial 2 □ Cremation 3 □ Removal					
Part   Comment	permit. Departi Import any inj		> Jeth Ull	Ru	ck Towson Funeral	Home	1050 York Towson, MD	Road
FFEMALE:   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   4   Pregnant at time of death   9   Unknown   1   Yes   2   No   3   Probably 4   Unknown   1   Yes   2   No   3   Probably 4   Unknown   9   Unknown   1   Yes   2   No   3   Probably 4   Unknown   1   Yes   2   No   3   Probably 4   Unknown   1   Yes   2   No   3   Probably 4   Unknown   1   Yes   2   No	/Medical Examiner	icai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events c.	te to (or as a consequence of):		or respiratory arross		Interval Between Onset and Death
25. Was case referred to medical examiner?    Secretary   Part	the death certific. by the attending places to use as t	hysician/Med	23b. Was decedent pregnant in the past 12 months?	ive birth 2 Fetal death 3 l				,
25. Was case referred to medical examiner?    Subject of Death   Check only one	quires that en signed t	þ	Part II. Other significant conditions contributing	to death but not resulting in the und	derlying cause given in Part I.			6
27. Manner of Death 1   Inpatient   2   EMOutpatient   3   DOA   4   Nursing Home   5   Residence   6   Ather (Specify)   Number   27. Manner of Death 1   Natural   27. Manner of Death   1   Natural   28. Date of Injury   on: The law re ificate has be or, page 2 sho		25. Was case referred to medical			autopsy performed 1 Yes 2	prior to com death?	npletion of cause of	
D 58303 - June 2 2005	fing Phy n. After this funeral d	40	examiner? 1  Yes 2 No  Hospital:  7. Manner of Death 1 Natural 5 Pending		3 DOA Other: 4 Nursing Ho 28c. Injury at Work?	ome 5 Residenc	e 6 × ther (Specify, injury occurred	nasjig
D 58303 - June 2 2005	ef or Atte s after dea al Directo	Certifica	determined 286.	Place of Injury - At home, farm, streen uilding, etc. <i>(Specify)</i>	et, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Itate)	Route Number,
D 58303 - June 2 2005	he Hospil in 24 hour he Funer pletely fill	edical	(Check only 2 Medical Examiner: On t	he basis of examination and/or inve	occurred at the time, date and place, estigation, in my opinion, death occurr	and due to the caus red at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AADAN (WALL WO) (COO) N. Macales Ct. Tools IV M. D. 21204	To t With To t	Σ	29b. Signature and light of certifier	cw.	D58303	11/	Ne 2 20	205
State 31. Date filed (Month, Day, Year) 32 Registrar's Signature			ATRON Charks	MD 6601 N.C	Lint)	MOCING	MD 2121	04

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7:55 AM

6-2-05

BROWN, FREDERICK

 $\beta L_{RN}F_{\nu RD}, \ \beta \bar{\epsilon}_{NJRm, L}$  Division of Vital Records, P.O. Box 68760,

		1 - For State Registrar	State of Maryland	/ Department of Certificate of			211115	1800
Physic	ian	Decedent's Name (First, Middle, L.		Gorimeate of			ay Year	3. Time of Death
/Medi Exami		Benjamin B  4a. Facility Name (If not institution, g  AINT AGNE.	ive street and number)  HEALTH CARL	E BA	or Location of Death	- 4	c. County of Death	/3.3 / M
Funeral Director		214-54-8250 Usual Residence of Decedent	Sex 1X M 2 F 7. Age (In yrs. las	Yrs. Months Days	Hours Min.	B. Date of Birth (Month, Day, Yea Ppt. 6 1	949 Mar	place (State or Foreign htry) Yland
e Marylar 8e-f show	Director	10a. State 10b. County  Maryland Anne A	_	Town or Location polis			1	0d. Inside City Limits  1X Yes 2 □ No
th with th	al Dire	10e. Street and Number  29 W. Washingt	on St. Apt.50	10f. Zip Code 2 2140	)1	10g. C	itizen of What Cour	Mil.
be filed within 72 hours after death with the Maryland tal Hygiene.  Ad other than "natural", or items 23a or 28e-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  **Mever Married 2   Married 3   Widowed 4   Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 1969 —	13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Spec pan, Mexican, Puerto Ri Specify:	ify Yes or No- ican, etc.)	14. Race - Americ Black, White, Specify: BLA	ean Indian, etc.
within 72 ho iene. r than "natur	Completed	15. Decedent's (Specify only highest g  Elementary/Secondary (0-12)  11th	ducation	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of working ed)	7	Kind of Business/Inc	
B a a b	To Be Co	17. Father's Name (First, Middle, Las Charles Blar	t)	Labore	18. Mother's Name (			Loyed
ic, Marylors and Should f Health and Meritem 27 is marked other treumatic		19a. Informant's Name/Relationship Lorraine Blandf	ord (Sister)	19b. Mailing Address (Stree 3838 Reger	t and Number or Rural i	Route Number, City	or Town, State, Zip	
Page nent o nnt: If		20a. Method of Disposition  Y⊠ Burial 2 □ Cremation 3  '4 □ Donation 5 □ Other (Spec	Removal from State Che	e of Disposition (Name of letery, crematory or other pla ltanham Vet etery	ceran 6/6/	200.	ocation - City or To	wn, State
permit. Departn importe any inju		21. Signature of Funeral Service Lice	Peese M00483	22. Name and Addr Wm. Rees 821 West	se & Sons St. Anna	MOrtuar		
Pnysician /Medical Examiner		23a. Part1. Enter the disease, or con shock, or heart failure. List ont Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	myocardial int		respiratory arrest,	i	Approximate Interval Between Onset and Death Vn Kn WN
ificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent c.     Due to (or as a consequent d.					
The law requires that the death certifics to has been signed by the attending phage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of death 9 Unknown	ath 3 Ectopic pregnance	у		23d. Date of deliver	ry Day Year
w requires that been signed b	by	Part II. Other significant conditions	contributing to death but not resultin	ng in the underlying cause gr	ven in Part I.	23e. Did tobacco	use contribute to the	
	Completed					24a. Was an autopsy performed?	prior to com death?	osy findings available inpletion of cause of
Phys this	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date of Injury 28l	/Outpatient 3 DOA Ott			6 □Other (Specify)	)
To the Hospital or Attending within 24 hours after death of the Funeral Director. After completely filled in by the funer	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not to determined	08 Place of Injury At home	Injury Wo	rk? Yes 2 □ No		nd Number or Rural	Route Number,
To the Hospital or Attent within 24 hours after that To the Funeral Director: completely filled in by the	edical Ce	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	nysician: To the best of my knowled miner: On the basis of examination and manner stated.	dge, death occurred at the ti and/or investigation, in my o	me, date and place, and opinion, death occurred	d due to the cause(s at the time, date an	and manner as sta d place, and due to	ated. the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier	MD	29c. Licens			te signed (Month, D	
2+1		30. Name and address of person who	completed cause of death (Item 23.	a) (Type, Frint) Balt	more, MD	21229		
Sta Registr	4	31. Date filed (Month, Day, Year) JUN 0 7 2005	32. Registrar Jaignatus	asse.				

		For State Registrar  1. Decedent's Name (First, Middle, Las	Ce	artment of Health and rtificate of Death	Reg.	No.2005	3. Time of Death
Physici /Medic Examir	cal .	Enikoe Maria Car 4a. Facility Name (If not institution, give 6501 Sherwood R		4b. City, Town, or Location of Deat  Baltimo	JUNE (	4c. County of Death Baltimore	5:45 A M
Funeral Director		5. Social Security Number 6. S 216-32-1879 1  Usual Residence of Decedent	ex 7. Age (In yrs. last birthday)  M 2XF 75 Yrs.	If Under 1 Year   If Under 24 Hrs   Months   Days   Hours   Min.		9. Birthp Cour 1930 Hung	
8a-f show	Director	10a. State 10b. County MD Baltimo	ore Baltimor	re			0d. Inside City Limits
23a or 2	rai Dir		oad	10f. Zip Code 21239	U	nited Stat	es
permit. Fages I and 2 should be lied within 72 hours after bean with the maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Byging content if the m27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examinar rotal be notified at once.	l by Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 No Specify:	to Rican, etc.)	Black, White,	etc.
within 7.5 ha lene. than "natu the Macical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed) (Give life.	edent's Usual Occupation a kind of work done during most of wo DO NOT use retired) emaker	rkina	o. Kind of Business/Ind Wn Home	dustry
should be fried wind Mental Hygie I marked other tumatic event, to	To Be Co	17. Father's Name (First, Middle, Last) Csaba Hanyi		Jolan	me (First, Middle, Mai		
and z sno ealth and I n 27 is ma		19a. Informant's Name/Relationship ( John Hallman Carp	//	ing Address (Street and Number or R 1 Sherwood Road			Code)
rages I a nent of He ant: If Item ury or othe		20a. Method of Disposition  1 Burial 2 Cremation 3   4 Donation 5 Other (Specify	Removal from State (20b. Place of Disposite cametery, cre (Chesape	osition (Name of matory or other place) ake Crematory Inc	Jun 7	e.Location - City or To	
Departr Departr Imports any inju		21. Signature of Funeral Service Licer		2 Name and Address of Eacility Cremation and Fune 8717 Green Pasture		tives ltimore, Ma	aryland 21
hysician /Medical Examiner		23a. Fart . Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		iter the mode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
te be executed ysician and e burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  Due to (or as a consequence of):  d.				
rife law requires that the death certification to the steep special to the attending phoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2(M)No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)	<i>්</i> .	23d. Date of deliver	ary Day Year
w requires that been signed b should be deta	þ	Part II. Other significant conditions of	contributing to death but not resulting in the t	underlying cause given in Part I.	23e. Did tobac	co use contribute to the	
	Completed				24a. Was an autopsy performed	prior to co death?	psy findings availabl mpletion of cause of 2 XNo
Auending rinysician: The rideath. ector: After this certificate haby the funeral director, page	ition: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  12 Natural 5 Pending investigation	Hospital: 1 Inpatient 2 ER/Outpatie  28a. Date of Injury (Month, Day Year)  28b. Time of Injury	ont 3 DOA Other: 4 Nursing	eth (Check only one)  Home 5 X Residence  28d. Describe how		y)
To the Hospital of Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, si building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rura State)	al Route Number,
lo the Hospital or within 24 hours afte To the Funeral Dirt completely filled in I	edical (	29a. Certifier Check only one) Certifying Pt Medical Exam	nysician: To the best of my knowledge, dea miner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)
vithin 2 To the complet	Me	29b. Signature and title of certifier	MD	29c. License number  RES - OC , Print)  S HOSPITAL 600 No.		Date signed (Month,	
$\sim$				7		1115 1167	11110

			For State Registrar	State of M	laryland		artment <i>rtificate</i>			Mental H	lygiene Reg. No		18907	
	Physic		Decedent's Name (First, Middle, I			~· .				2. Date of Month	Death Da		3. Time of Death 8:00 a.m	
	/Medi Exami		4a. Facility Name (If not institution, g	Adline iive street and number		Charl		own. or	Location of Deat	<u>5</u>	26	2005 County of De		
	LAGITIII		1104 Laurens Si		,		Ba1		2004(011 01 204)		1	N/A	aui	
	Funeral			Sex 7. A	ge (In yrs. las	st birthday)	If Under 1	Year	If Under 24 Hrs		Birth	9. Bi	rthplace (State or Foreign	
	Director		212-28-5094	1 □ M 2 <b>X</b> 1F	81	Yrs.	Months	Days	Hours Min.		Day, Year) 5-192	- 1	Country)	
	and		Usuat Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	cation							
	Marylan f show	ō		*									10d. Inside City Limits 1 1 1 Yes 2 No	
	286 286	Director	10e. Street and Number	N/A	L Ba	alto_	10f. Zip C	ode			10a Ci	izan of Milat C		
	3a or	ō	1104 Laurens S	Street			TOI. ZIP C		1 1 7			tizen of What C	ountry?	
	72 hours after death with the Maryland natural; or Items 23a or 28e-f show disal Examiner must be conflided at	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13.1	Vas Decede	212	Z <b>I /</b> spanic Origin? (S i, <b>M</b> exican, Puerl	ipecify Yes or		S A 14. Race - Am	erican Indian.	
ထွ	after or Ite	E	1 Never Married 2 Married	Armed Forces  1 Tes 2 Tes		1				to Rican, etc.)		Black, Whi	ite, etc.	
8	ural',	d by	3 Widowed 4 Divorced	Year or Dates:			Yes 2	ΧNO	Specify:			Specify: B	lack	
21215-0036		Completed	15. Decedent's (Specify only highest g	Education rade completed)		(Give	ent's Usual kind of work	done du	uring most of wor	rking		ind of Business		
12	i within iene.	m d	Elementary/Secondary (0-12)	College (1-4or			oo NOT use Tolder	retired)				Regal L	aundry	
d 2	라 다 를 수 를		8th grade 17. Father's Name (First, Middle, Las	N/A					18. Mother's Nar	no (Eirot Mint	do Maidos	(Cumpany)		
an	0 0 0 0	o Be	Abraham Charles	,								Sumame)		
Maryland	2 should be f and Mental I is marked of aumetic eve	P				19b. Maitin	n Address /	Street as				r Tourn State	Zin Code)	
	and 2 lealth a m 27 is												210 0000)	
Baltimore,	1 to 1		20a. Method of Disposition			e of Dispo	sition (Name	of		Date	-		r Town, State	
Ē	Pages nent of I ant: If its ary or o		1 ☑ Burial 2 ☐ Cremation 3 1 ☑ Donation 5 ☐ Other (Spec	□Removal from State cify)	' i					_2005	Done	Jo 1 1 a + a	MJ	
븚	permit. Pages Department of Importent: If i any njury or once.	11		Informant's Name/Relationship (Type, Print)  Alvesta Cooper-Daughter  19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  1104 Laurens Street Balto, Md 21217  20b. Place of Disposition (Name of cemetery, crematory or other place)  King Memorial Park  22. Name and Address of Facility March F/H West  4300 Wabash Avenue Balto, Md 2121										
m	Department of the sany		19a. Informant's Name/Relationship (Type, Print)  Alvesta Cooper-Daughter  19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, 19b. Maiting Address (Street and Number											
			23a. Part1. Enter the disease, or conshock, or heart failure. List on	mplications that cause	d the death.	Do not ente	r the mode	of dying,	such as cardiac	or respiratory	arrest,		Approximate	
鷌	Pnysician	9 1	tmmediate Cause (Final			E I	ZENA	ا ــا	DISEA	SE			Interval Between Onset and Death	
	/Medical		transdiate Cause (Final disease or condition resulting in death)  END STAGE RENAL DISEASE  Due to (or as a consequence of):										6 WEEKS	
	Examiner		Sequentially list conditions		ONIC		DNE	1	DISEA	SE			3 YEARS	
	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		à conseque	•		0.0						
	and and I-tran	хап	that initiated events resulting in death) Last	c. 1141 Due to (or as	er te		N	_					10 YEARS	
8760,	cate be executed physician and the burial-transit	a E		Due to (di as	a consequer	ice oi):								
	icate phys s the	dicai		d	-									
×	death certific e attending p nd for use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnance	v						204 0 ( )		
Вох	that the death cer ed by the attendir detached for use	Physician/M	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal de	ath 3	Ectopic preg Other <i>(spec</i>					23d. Date of de Month	Day Year	
0	t the d by the tached	hysi	1 Yes 2 No 9 Unknown	9 Unknown			- man (opera	.,,						
S, T	The law requires that the tite has been signed by thogge 2 should be detached.	by P	Part II. Other significant conditions	contributing to death b	ut not resultir	ng in the un	derlying cau:	se given	in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?	
ğ	w require been sig should b		HORTIC INSI	AFFICIE	NCY					10	]Yes 2[	□No 3□Pr	robably 4 Unknown	
Kecord	aw requisite been 2 should	piet	HEART FAIL	MRE	•					24a. Wa	is an	24b. Were au	utopsy findings available	
ř	The lav	Completed					-			_ per	opsy formed?	prior to death?	completion of cause of	
I a	certificate	Bec	25. Was case referred to medical					2	26. Place of Dea	1 ☐ Yes th (Check only	one)	1 ☐ Yes	2X No	
Division of Vital	G 5: 5	10	examiner? 1  Yes 2 No	Hospital: 1 ☐ Inpatie	ent 2 ER	/Outpatient	3□ DOA	Other:				Other (Spe	cify) Daughter's	
	h. After th funeral		27. Manner of Death  1 Natural 5 Pending	28a. Date of Inju (Month, Da	ry 28 y Year)	b. Time of Injury	28c.	Injury a Work?		28d. Describe		**	nouse	
<u>S</u>	Attending ar death. ector: After by the funer	cati	2 Accident investigation				М		s 2□No					
₹ :	al or Attend after death Director: / d in by the f	Certification;	3 Suicide 6 Could not 1 4 Homicide determined		ury - At home c. (Specify)	, farm, stre	et, factory, o	ffice		28f. Location City or T	(Street and own, State)	d Number or Ru	ural Route Number,	
ا د	urs elle													
-	e Hospital 124 hours a e Funerel I letely filled	edical	29a. Certifier (Check only one) Certifying P	hysicien: To the best	i examination	dge, death and/or inv	occurred at to estigation, in	he time, my opin	date and place, ion, death occur	and due to the red at the time	e cause(s) , date and	and manner as place, and due	stated. to the cause(s)	
	within 24 hours a voithin 24 hours a To the Funerel I completely filled		28b. Signature and title of certifier	and manner sta	Alou.									
1	3 - 3	1	· A bA	1 MI	D		-50.0	LES	-000	5	di A	3 7 7 7	7.00 C	
1	201	1	30. Name and address a parson who		eath (lta- co	a) (Tue - "	riot)				har w	104	,	
1			30. Name and addre so person who	ICCINI /	MD	600	NW	OLF	E ST.	BALTI	MORE	E,MD	n, Day, Year) , 2005 21287	
	Stat	•	31. Date filed (Month, Day, Year)	32. Registra	ar's Sanature	) ,	, 7	a K	,					
	Registra		111	N 0 7 2005	MARIA	בא גע	The first of the second	-						

**Physician** /Medical

Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Importent: If item 27 is marked other than "natural", or iteme 23s or 28s-f show any injury or other treumatic event, Ira Medical Examiner court by notified at once.

Pnysician

Be Completed by Funeral Director

္ဝ

Examiner

Completed by Physician/Medical

Be

To 27.

Medical Certification:

Plea	ase Type or P	rint in Bl	ack In	idelible lnk.	Ensure #	All Copies /	Are Leg	ible.	
For State Registrar			l / Depa	artment of He	lealth and M	Mental Hygi		)5	8908
1. Decedent's Name (First, Middle	lark Jr.					2. Date of Death Month May	h Day	Year	3. Time of Death 4:15 A
4a. Facility Name (If not institution VA Maryland Hea				4b. City, Town, or Perry Po			4c. County Ceci	y of Death	*****
5. Social Security Number 073-34-1250	6. Sex 7. 1 M 2 ☐ F	7. Age (In yrs. lasi 60	st birthday) Yrs.	If Under 1 Year     Months   Days	If Under 24 Hrs. Hours Min.			Country)	ce (State or Foreig
Usual Residence of Decedent  10a. State  VA  Fair		10c. City, 7	Town or Lo	ocation exandria					I. Inside City Limits 1.   1.   1.   1.   1.   1.   1.   1.
10e. Street and Number 5612 Bismach	Drive T2			10f. Zîp Code 22312	2	10	0g. Citizen of V USA		?
11. Marital Status  1 Never Married 2 Marr 3 Widowed 4 Divorced	ried 1 XYes 2	2 🗆 No		Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 🛣 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		ce - American ck, White, etc. fy: Blac	D
(Specify only highes Elementary/Secondary (0-12)	nt's Education est grade completed)  College (1-4		(Give life. L	dent's Usual Occupat a kind of work done du DO NOT use retired)	during most of work )	rking	16b. Kind of Bu		try
12 17. Father's Name (First, Middle, Samuel Clark	5+		M1 T T	itary Vete		me (First, Middle, Ma			
19a. Informant's Name/Relations Chol Cha Clark	ship (Type, Print)			ng Address (Street ar 2 Bismach	and Number or Rui	ural Route Number,	-		ode)
20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (S)		cemi	ce of Dispo:	osition (Name of matory or other place, National Cen	e)	Date 20	Calverto	City or Town,	, State
21. Signature of Funeral Service	0	,		1501 Fast I	Stevens F Fort Ave.	Funeral Home Paltimone M	MD 21230		
23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition		used the death. I ch line. ic Shock						Ap Int On	pproximate iterval Between nset and Death Iknown
resulting in death)  Sequentially list conditions.	Due to (or A.S.)	r as a consequen	nce of):					1220	ars
f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<b>S</b> c	r as a consequen							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 Fetal dei nt at time of death	eath 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date Mon	te of delivery onth Day	ıy Year
Part II. Other significant condition	ns contributing to deat	th but not resultin	ng in the un	nderlying cause giver	n in Part I.				cause of death?
						24a. Was an autopsy performe	ed? d	Were autopsy prior to comple death?	findings availabletion of cause of
25. Was case referred to medical					26. Place of Dea	th Check onl one			N
examiner? 1 ☐ Yes 2 ☐ <b>X</b> No	Hospital: 1 X Inp	natient 2 ER	3/Outpatient			lome 5 Residen		or (Specify)	
27. Manner of Death  1 Natural 5 Pending 2 Accident investig	28a. Date of I (Month,		8b. Time of Injury	f 28c. injury a Work?	at	28d. Describe how	/ injury occurre	ed	
3 Suicide 6 Could r	not be ined 28e. Place of	I Injury - At home	a, farm, stre	eet, factory, office		28f. Location (Stree	set and Number	er or Rural Ro	oute Number,

/Medical **Examiner** To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

nan 9

01010580281

29d. Date signed (Month, Day, Year) 26/2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VA Maryland Health Care System Perry Point, MD Jianyi Zhang, M.D. 21902 31. Date filed (Month, Day, Year)

State Registrar

32. Registrar's Signature JUN 017 2005

			For State Registrar	State o	f Marylan		artment of rtificate o			ental Hygi	ene 0 0	5	18909
			1. Decedent's Name (First, Middle	, Last)						2. Date of Deatl	1		3. Time of Death
	hysici /Media		Vincent	Cusimano					1	Month May 27,	Day Y 2005	/ear	3:00 P M
1	xamir		4a. Facility Name (If not institution		nber)		4b. City, Town	, or Location o		11th y 27 5	4c. County of	Death	3.00 1
			8109 20th Avenu	ue			Ade]	Lphi			Prince	Geor	ge's
Fu	ineral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Day	ar   If Under 2	24 Hrs. Min.	8. Date of Birth (Month, Day,			ace (State or Foreign
Dir	ector		577-12-1173	<b>1</b> √2 M 2 □ F	91	Yrs.	World Day	Tiodis	(	08/22/19			ngton, DC
and	*		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					100	d. Inside City Limits
haryla	Sho B	ō	,		100.00	ty, rown or Eo	cation					104	a. Inside City Limits 1 XYes 2 □ No
the A	28e-1	Funeral Director	Maryland Prince	George's	A	delphi	104 7:- 0-4-			1.,	633		
with	o d	D.					10f. Zip Code			10	g. Citizen of Wh.		y?
eath	78 Z3	era	8109 20th Avenu		dent Ever in U	S 12 1	20783		2102 (0000		U.S.A		- Indian
ter d	E a	Ē	1 ☐ Never Married 2 ☐ Marri	Armed For	rces?	.5.	Was Decedent of Yes, specify Cu	uban, Mexican	, Puerto R	lican, etc.)	14. Race - Black,	White, et	
	o, le	by	3 Widowed 4 Divorced	led 1 □ Yes If Yes, Giv Year or Da	entes:	'	I□Yes 2□xN	lo Specify:			Specify:	whit	e
d 21215-0036 Illed within 72 hours after death with the Maryland Hygiene.	ical	Completed	15. Decedent	's Education			ient's Usual Occ			1	6b. Kind of Busir	ness/Indu	ıstry
24 e	Med	ple	(Specify only highes Elementary/Secondary (0-12)	College (1	·4or 5+)	life. L	kind of work dor DO NOT use reti	ne during most ired)	of working	g			,
d 21 filed wit Hygiene	를	on	12	Conlege (1	401 017	Feder	ral Empl	lovee			Govern	ment	
be file	Vent	Be (	17. Father's Name (First, Middle, I	Last)					r's Name	(First, Middle, M			
aryla  should b ind Ment	utic e	To I	Leonardo Cusima	ano				Victo	ria A	Ardizzor	ıe		
Maryland 21215-0036 The 2 should be filled within 72 hours af	Important: it tam 27 is marked other than "natural, or itams 23a or 28e-f show any injury or other traumatic event, the Medical Examinar must be indiffed at pince.		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailin	g Address (Stre	et and Numbe	r or Rural	Route Number,	City or Town, Sta	ate, Zîp C	ode)
and and	n 2/		Annette Theresa	Youngs/Da					nham	, MD 207	06		
Baltimore, sermit. Pages 1 ar Department of Hea	r oth		20a. Method of Disposition 1 △ Burial 2 □ Cremation	2 DRomovel from 6	20b. P	lace of Disposemetery, crem	sition (Name of natory or other p	lace)	Da	ite 2	Oc. Location - Cit	ty or Tow	n, State
Pages	ury o		'4 □Donation 5 □ Other (Sp		nate		coln Cen		6/01/	/2005 Br	entwood	, MD	
Balt permit. Departr	any inju		21. Signature of Funeral Service L	ic see						Lincolr		,	
<b>m</b> & 2 3	E & 8		Xan T. J	We		34	401 Blad	lensbur	g Rd	. Brentw	ood, Md	207	22
100			23a. Pack. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	complications that ca only one cause on ea	used the death ach line.	h. Do not ente	er the mode of d	ying, such as o	cardiac or	respiratory arre	st,	la la	Approximate nterval Between Onset and Death
Phys /Ma	ician dical		disease or condition resulting in death)	_ a. Myelo	dysplas	stic Sy	ndrome						Years
	niner			Due to (	or as a consequ	uence of):							
		<u>-</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (	or as a consequ	uence of\:						-	
pet	nsit	Examiner	Cause (Disease or injury	3.00.00	. 40 4 0011004	301100 017.							
хөсп	al-tra	xar	that initiated events resulting in death) Last	c. Due to (c	or as a consequ	uence of):			_			=	
ate be executed	the burial-transit	ical E											
OS/	s the	TO		d.								_	
death certific	for use as [	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo							23d. Date o	f dolinos	
g dath a	d for	cial	in the past 12 months?		nth 2 ☐ Fetal ant at time of de		Ectopic pregnan Other (specify)	су			Month	-	ay Year
j š	tached	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno			and (aposity)						
ords, P.O	deta		Part II. Other significant condition	ns contributing to de	ath but not resu	ulting in the un	derlying cause g	given in Part I.		23e. Did toba	cco use contribu	ite to the	cause of death?
ras quire:	should be deta	d by								1 ☐ Yes	2 <b>™</b> No 3[	☐ Probab	oly 4 🗆 Unknown
2 < ()	shou	Completed								24a. Was an	24h Was	ro autono	y findings qualable
<b>a</b> a a	9 2	m a								autopsy	priq	r to comp	y findings available detion of cause of
	or, pa	e Co	25 Was again referred to medical							1 □ Yes 2X	XNo 1 □	Yes 2	□ No
		o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:			0	ed.		Check only one			
Phy el		Project Company	1 ☐ Yes 2☐No 27. Manner of Death	28a. Date o		ER/Outpatient 28b. Time of	3□ DOA 28c. Inj	4   1401:		e 5 <b>X</b> Residen ld. Døscribe hov	ce 6 Other	Specify)	
ding h.	funer	tion	1 Natural 5 ☐ Pending	(Month	, Day Year)	Injury	W	ork? □Yes 2□N		id. Doscribe Nor	injury occurred		
DIVISION  for Attanding after death. Director: Ate	y the	ertification;	3 ☐ Suicide 6 ☐ Could n	ot be	of Injury - At ho	ome farm stre	et, factory, office			If Location (Stre	et and Number o	or Rural F	Poute Number
after Direct	filled in by	erti	4 ☐ Homicide determin	buildin	g, etc. (Specify	1)	ot, lactory, office			City or Town,	State)	n riurar r	oute Number,
UIVISION To the Hospitel or Attending within 24 hours after death. To the Funarel Director: After	) He	O	29a. Certifier XXCertifying	Physicien: To the	pest of my know	wledge, death	occurred at the	time, date and	place an	d due to the cau	Sa(s) and manns	ar ac ctat-	
24 h	etely	edicai	(Check only 2 Medical E	xaminer: On the ba	sis of examinat	tion and/or inv	estigation, in my	opinion, death	n occurred	at the time, dat	and place, and	due to th	e cause(s)
Vithin	completely		29b. Signature and little of certifier	11111	0 11		29c. Licer	nse number		290	. Date signed (N	fonth, Da	y, Year)
r. > F	-		► \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	VVVVV	( ) M	)	D215	531			5/31/200	05	_
/		-	30. Name and address of person w	no completed cause	of death (Item	23a) (Type F							
4			Gabriel Peter F					DA D	0.01222	11a MD	20052		
	Stat	e	31. Date filed (Month, Day, Year)	32. Re	gistrar's signat	ture "	rgerown	· Nu · R	OCKV1	ille, MD	20002		
R	egistra	ar	JU	N 0 7 2005	Here	w St.	Sport						

			1- State of Maryland / Dep State of Maryland / Dep	artment of Health and ertificate of Death	* -	one 005 18910
			Decedent's Name (First, Middle, Last)	runodio oi bodiii	2. Date of Death	3. Time of Death
	Physici		FREDERICK JOHN CHAMBERS		Month JUI	Day Yeer
	/Medio Examir		4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center	4b. City, Town, or Location of Dea		4c. County of Death Baltimore
	Funeral		5. Social Security Number  6. Sex 7. Age (In yrs. last birthday, 136–10–5314  7. Age (In yrs. last birthday, 136–10–5314	If Under 1 Year   If Under 24 Hrs   Months   Days   Hours   Min	. (Month_Day, Y	9. Birthplace (State or Foreign Country)
	Director		136-10-5314 X W 2 96 Yrs. Usual Residence of Decedent		Nov 5, 1	New Jersey
	yland		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	he Mar 8a-f st	Director	Maryland Baltimore County Towso	·	····	1 ☐ Yes 2 📆 No
	h with t		10e. Street and Number  4 Airway Circle, Apt 2B	10f. Zip Code 21286	10g	. Citizen of What Country? USA
	deat	Funerai		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - American Indian,
21215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. Ital Hygiene. Id other than "natural", or Items 23a or 28a-1 show event, the Medical Exercites must be rediffed at	by	1 □ Never Married 2 ☑ Married  1 □ Yes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	rto Hican, etc.)	Black, White, etc.  Specify: White
2-0	72 ho natur lical	sted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation a kind of work done during most of wo	ndking 16	b. Kind of Business/Industry
2	vithin ne. han	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		Gasoline Corporation
2	filed wii Hygien other th	CO	17. Father's Name (First, Middle, Last)	Auditor	me (First, Middle, Ma	
Maryland	should be filed within nd Mental Hygiene. marked other than " Imatic event, Ite Max	To Be	George Thomas Chambers		Marie Wag	
ary		_		ng Address (Street and Number or R		
	1 and 2 Health a tem 27 is		Laurel Jeanne Chambers (Wife) 4 Ai	rway Circle, Apt	2B, Towso	n, Maryland 21286
ore		1	20a. Method of Disposition 1 ☐ Burial 2 to Commation 3 ☐ Removal from State  20b. Place of Disposition certainly, cre-	osition (Name of matory or other place)	Date 20	c. Location - City or Town, State
altimore,	. Pages tment of I tant: If it		`4 □Donation 15 □Other (Specify) Green Mo	unt Cemetery 6/4	/2005 B	altimore, Maryland
Ra	permit. Page Department Important: If any injury or		Marin Mawson M	2. Name and Address of Facility Litchell-Wiedefeld 500. Vork. Boad. Bo	1 Funeral 1	Home, Inc.
П			Martin D. Lawson  23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardia	c or respiratory arrest	Interval Between
	Physician		Immediate Cause (Final disease or condition ACLITE MYCCARD)	IAL INFARCTION		Onset and Death  1 WEEK
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events			
Ď,	e exection and an arrial-tr	Exa	resulting in death) Last Due to (or as a consequence of):			
9/8	icate be executed physician and s the burial-transit	edicai	d			
٥ ×		/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			
X Q Q	death certif e attending id for use a	Physician/M	in the past 12 months?  1 Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery  Month Day Year
j.		hysi	9 Unknown	- (-F 7/		
	law requires that the de as been signed by the 2 should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
cords,	equire sen si ould l	ted	CONGESTIVE HEART FAILURE		1 🗋 Yes	No 3 Probably 4 □Unknown
d)	has be	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
	i: The cate hat; page				performed 1 ☐ Yes 2	death? No 1 ☐ Yes 2 ☐ No
Vital	sician certif rector	Be	25. Was case referred to medical examiner?  Hospital:	Othor	ath (Check only one)	
ō	Physic arthis seal di	٦. ا	27. Manner of Death 28a. Date of Injury 28b. Time o	IL SELDON 4E NUISING P	fome 5 Residence 28d. Describe how	e 6 Other (Specify)
0	nding th. r: Afte e fune	atior	1 Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		,
UNISION	or Attending Physician: ifter death. Director: After this certific in by the funeral director.	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number,
5	oitel or urs aft ral Dii lled in	O				
	To the Hospitel or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	e, and due to the caus urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
			( Knul 5)	D 37254	6	11/05
	6		30. Name and address of person who completed cause of death (Item 23a) (Type,		VI (NUTS COLO	D(7)(A
	Sta Registr	2	31. Date filed (Month, Day, Year)  11. N 0 7 2005	IVE TOWSON MAR		L and
			IIIN II / LOUS PORTERS IN			

			. For	State of Mary	yland / De	partment of	Health and	Mental Hygi	ene	10011
		_1	State Registrar		С	ertificate of	Death		g. No. UUD	18911
Phy	ysicia		1. Decedent's Name (First, Middle, Last)	_				2. Date of Death Month	Day Year	3. Time of Death 5 10:31 A M
/M	ledica amine	al -	John David Come  1a. Facility Name (If not institution, give str			4b. City, Town,	or Location of Dea	HUNE	3 ZOO 4c. County of Dea	
Exa	amine	-	Upper Chesapeake Me		ter	Bel A			Harford	
Fune			5. Social Security Number 6. Sex	7. Age (II	n yrs. last birthda	Months Day				thplace (State or Foreign ountry)
Direc	ctor	-	Usuat Residence of Decedent		O Yrs			Dec. 27		ginia
yland	74		10a. State 10b. County	10	Dc. City, Town or	Location				10d. Inside City Limits
e Mar	diffee	ctor	Maryland Harford		Edgewo	od				1 ☐ Yes 2 ☑ No
death with the Maryland ms 23a or 28a-f show	SU BO	Directo	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
leath ns 23	T I	by Funeral	875 Clover Leaf Co	. Was Decedent Eve	er in U.S. 1	3. Was Decedent of		Specify Yes or No-	USA 14. Race - Ame	erican Indian,
after o	miner	Ξ	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		3. Was Decedent of If Yes, specify Cu		to Rican, etc.)	Black, Whi	
d ZIZIO-0030 filed within 72 hours after Hygiene. ther than "neturel", or ite	Exa	d b	3 ☐ Widowed 4 ② Divorced	Year or Dates:		1 □ Yes 2 □ N			Specify: Wh	
in 72 l	edice	Completed	15. Decedent's Educa (Specify only highest grade of	completed)	(G	cedent's Usual Occ ive kind of work don a. DO NOT use reti	e during most of wo	orking	6b. Kind of Business	•
d with giene.	200	mo:	Elementary/Secondary (0-12)	College (1-4or 5+)	Heav	y Equipme	ent Mechai	nic	Baltimo County Gor	
be file tal Hyg	vent.	Be	17. Father's Name (First, Middle, Last)			2 - 1 - 1		me (First, Middle, M	aiden Sumame)	
y ca	natic		John David Comer,	Sr.	405.14		1		ampbell	7.0.41
If E, INIALYIATION ZIZIO-UUOO s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "neturel", or Items 23a or 28a-1 show	treun		19a. Informant's Name/Relationship (Type David W. Comer - Se						City or Town, State, LOwings M	2111/
of Hear	other	ŀ	20a. Method of Disposition			sposition (Name of crematory or other p		-	Oc. Location - City or	
	ury or		1 Marial / 2 □ Cremation 3 □ Rer `4 □ Doration 5 □ Other (Specify)	moval motificate		on Cemete		/2005 I	Darlington	, Maryland
Dalling permit. Pag Department Importent:	eny ing		21. Sign ture of Fu Ava Savice Licensee			22. Name and Add McComas E	ress of Facility Funeral Ho	ome, P.A.		
405	• a	-	23a Part1. Enter the disease, or complica	ations that caused the		1317 Coke	sbury Rd	., Abingdo	on, Maryla	Approximate
Physic			shock, or heart failure. List only one	cause on each line.			20.	200		Interval Between Onset and Death
/Medi	ical		disease or condition resulting in death)	Massive Due to (or as a c	onsequence of):	TOINTE	STINCE!	HENOT	nage	15 Minutes
Exami	- 6	_	Sequentially list conditions, b.	Grad	e Fou	r Es	ophag	eal var	ices	8 days
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wrequires that the death certificate be executed been signed by the attending physician and	he bu	cal	d.							
X OX sertific ding p	se as	Physician/Med	IF FEMALE:	c. If yes, outcome of p	pregnancy				and Data of da	
Beath c	for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ( 4 Pregnant at tim	Fetal death	3 ☐Ectopic pregnar 5 ☐ Other (specify)	icy		23d. Date of de Month	Day Year
by the	tached	hysi	9 Unknown	9□ Unknown						
es tha	ep eq	þ	Part II. Other significant conditions contr				given in Part I.	19	,	o the cause of death?
2 in S:	hould	eted	. \1	Suppos	141014			1 ☐ Yes	s 2 <b>∆2</b> No 3⊟P	robably 4 Unknown
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To the Hospitel or Atlanding Physician: The la within 24 hours after death.  To the Funerel Director: After this certificate has	the funeral director.	e Medical Certifi atlon; To Be	25. Was case referred to medical examiner?  1	spital:  28a. Date of Injury (Month, Day Y.)  28e. Place of Injury building, etc. (cien: To the best of ear. On the basis of exand manner stated	28b. Tim Injuration At home, farm, Specify)  my knowledge, disamination and/od.  th (Item 23a) (Tyling Signature)	tient 3 DOA  a of 28c. In W M 1  street, factory, office eath occurred at the r investigation, in my 29c. Lice	other: 4 Nursing uny at ork? Yes 2 No e  time, date and place y opinion, death occurse number	24a. Was an autopsy perform  1 Yes 2  ath (Check only one  Home 5 Resider  28d. Describe how  28f. Location (Str. City or Town,	ed? death?  1 Yes  Other (Spewinjury occurred  eet and Number or R State)  use(s) and manner a te and place, and du  d. Date signed (Mon	utopsy findings available completion of cause of s 2 No secify)  Bural Route Number, s stated. e to the cause(s)  th. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item#5, perFH, C845, 7/1/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Pauline Hilda Cobo June 2005 13:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 2125020 9383 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1□ M 21\$7.F <del>217-05-1851</del> Yrs 90 9, Aug. 1914 Maryland Usual Residence of Decedent 10a State 10b Count 10c. City, Town or Location 10d. Inside City Limits Director Bel Air 1X Yes 2 No Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 226 Crocker Drive - Apt. D 21014 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 18b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be (unk) Gustave Rauser Monika (unk) Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John M. Cobo / son 11956 Mays Chapel Road, Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 6-6-05 Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee Marli 1-50 West Broadway, Bel Air, Maryland 21014 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA ASPIRATION disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner TERY DISEASE that initiated events resulting in death) Last ORONAKI Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Dav Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? g 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death Check onl one examiner? Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ျှ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No

**Physician** /Medical **Examiner** Box 68760 physician The law requires that the death certificate be the Records, P.O. certificate has Division of Vital this . After t or Attending death. Director: within 24 hours a To the Funerel L

**Funeral** 

Director

or 28e-f show

or Items 23e

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other treumetic event, the Medical Examinar must be notified at

with the Maryland

filed within 72 hours after

d 2 should be filed within a th and Mental Hygiene. T is marked other then "r

Pages 1 and 2 s ment of Health an permit. Pages 1 and 2: Department of Health au tmportent: If item 27 is any injury or other treuonce.

Baltimore, Maryland 21215-0036

2 Accident 3 Suicide 4 Homicide

29a. Certifier

Medical

State

Registrar

investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

There

29c. License number 026191 29d. Date signed (Month, Day, Year)

MD 21047

DANUSHA SIRITHARA 31. Date filed (Month, Day, Year)

JUN 0 7 2005

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2112 BELDIR ROAD, SUITE 10, FAUSTON,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 2005 June 1, **Physician** 8:55 A Dorothy Mae Christesen /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Hyattsville Sacred Heart Home Prince George's If Under 24 Hrs. 8. Date of Birth Month, Day, Feb 5, If Under 1 Year 9. Birthplace (State or Foreign Country)
Washington DC 5. Social Security Number 6. Sex 7. Age (In vrs. lest birthday) Funeral Days Months 1913 1 M XX F Yrs. 578 03 8880 92 Director Usuel Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryle Depertment of Health end Mantel Plygiene. Important: If Item 27 is marked other than "netural", or Items 23a or 28a-f shot any Injury or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2√3√No Directo Hyattsville Maryland Prince George's 10f. Zip Code 10g. Citizen of Whet Country? 20782 United States 5805 Queens Chapel Road Funerai 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 17tNo If Yes, Give 11.11 Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify. Specify: Be Completed by White 3 Vividowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Own Home Housewife 12 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John R. Currier Anna Macomber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7004 Killarney Street, Clinton, MD 20735 Anne Ramsey (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery June 6, 2005 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service;License 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, Maryland 20735 MO0257 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner or Attending Physician: Tha lew requires that the death certificete be executed es the bunal-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Division of Vital Records, P.O. Box 68760. Physician/Medical Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No þ 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has been si completaly filled in by the funeral director, paga 2 should I Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 X 100 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 1 Maturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 15 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medicai (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature end life of certifier .05 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) PPMAN STREET

State Registrar 31. Dete filed (Month, Gay

DHMH 16 Rev 6/95

			For Stata Ragistrar	State of Maryla		artment of I		d Mental H	ygiene Reg. No	CUU	18914
	Physici		1. Decedent's Name (First, Middle, Last, Thomas B. Ca	arroll, Sr.				2. Date of D Month	Day		3. Time of Death 12:45 P M
	/Medio Examir		4a. Facility Name (If not institution, give Southern Marylar	street and number)		4b. City, Town, Clint	on	eath	4c.	county of Death ince Geo	rge's
	Funeral Director		5. Social Security Number 6. Sec. 213 18 3111 X5	X 7. Age (In yr	rs. last birthday) 86 Yrs.	tf Under 1 Year Months Days		Hrs. 8. Date of 8 (Month, I	irth lay, Year) 1 22,	9. Birthp Cour 1919 Ma	otace (State or Foreign ntry) ryland
	ne Maryland Be-f show stiffed at	ctor	10a. State 10b. County Maryland Prince	George's	Clintor	1					0d. Inside City Limits 1 ☐ Yes ※※ No
	ath with ti	rai Dire	7003 East Clintor	Street		10f. Zip Code 2073	35			izen of What Cour ited Sta	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "naturel", or Items 23e or 28e-f show wayl injury or other treumetic event. Ite Medical Ever it ar missible trotified at ADRG.	Completed by Funeral Director	11. Marital Status  1 Never Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  XMYes 2 No WW 1f Yes, Give Year or Dates:	JTT	Was Decedent of If Yes, specify Cub 1 ☐ Yes 2XXVo		? (Specify Yes or N uerto Rican, etc.)	10-	14. Race - Americ Black, White, Specify:	
Maryland 21215-0036	within 72 ho ene. than "natur he Medical.	mpleted	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occu kind of work done DO NOT use retire 10USE Tec	during most of ad)			ind of Business/Ind	dustry ional Guard
land 5	uld be filed Mental Hygi arked other stic event, I	To Be Co	17. Father's Name (First, Middle, Last) Harry S. Car	croll, Sr.			18. Mother's I	Name (First, Middle Barry			
, Mar	and 2 sho salth and n 27 is ma		19a. Informant's Name/Relationship (Ty Clara Carroll (V	Vife)	7003	B East Cl	inton S	Rural Route Num treet, C			Code) 0735
Baltimore,	. Pages 1 Iment of Hu tent: if iter jury or oth		20a Method of Disposition  1	Ma	aryland	Veterans	Cemete	•	Che		Maryland
			21. Sign tu s of Funer I Service kioens  (3a Pan1. Enter the disease, or complessock, or heart failure. List only of Immediate Cause (Final	I Mood 57 ications that caused the dene cause on each line.	eath. Do not ent	exandria er the mode of dy	Ferry	ee Funera Road, Cla diac or respiratory	inton	me,Inc. , Maryla	6633 Old nd 20735 Approximate Interval Between Onset and Death
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.O. Box 6	death certif e attending od for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etat death 3	]Ectopic pregnand ] Other (specify) _	y		4	23d. Date of delive Month	ory Day Year
ords, P.	The law requires that the ate has been signed by the bage 2 should be detache	þ	Part II. Other significant conditions cor	ntributing to death but not r	esulting in the u	nderlying cause gr	ven in Part I.		tobacco u Yes 2[	se contribute to th	
Division of Vital Records,	: The law recate has be page 2 shu	Completed						24a. Wa auto peri 1 ☐ Yes		24b. Were autop prior to con death? 1  Yes	osy findings available inpletion of cause of
Žį.	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	fospital:		Ott		Death (Check only			
ion of		ation: To	1 Yes XXNo ]  27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Inju Wo	ry at	g Home 5 Res 28d. Describe			)
Divis	To the Hospitel or Attending within 24 hours efter death. To the Funerel Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be determined	28e. Ptace of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office		28f. Location City or To	(Street and own, State)	d Number or Rural )	Route Number,
	To the Hospitel within 24 hours e To the Funerei Completely filled	Medical	29a. Certifier   1	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death nation and/or in	n occurred at the ti vestigation, in my	me, date and pla opinion, death o	ace, and due to the courred at the time	cause(s) , date and	and manner as sta place, and due to	ated. the cause(s)
)	To t To tl	Ž	29b. Signature and title of confiler  Weekley	telino	>	29c. Licen:	400424	145	Jun	e signed (Month, L	2005-
	341		30. Name and address of person who co	NTELDO			POST E	PFICE	NON	2060	ζ
	Sta Registr	-	31. Date filed (Month, Day, You) 7 2	005 32. egistrar's Sig	nature A						

K	3		1 = For State Registrar	State of M	laryland .		rtmen <i>tificate</i>				-	gieņe Reg. <b>N</b> o.	005	189	15
	Physicia	an	1. Decedent's Name (First, Middle, La		•						2. Date of De	ath Day	Year	3. Time	of Death
	/Medic		Shirley Chisle								June 4,			3:04	Р м
	Examin	er	4a. Facility Name (If not institution, git						Location o	of Death			County of Dea		
	<b>-</b>		624 West Franklin  5. Social Security Number 6.		DL . 4 ge (In yrs. last	birthday)	If Under	1time	ore If Under:	24 Hrs.	8. Date of Bin		1timor	e City thplace (State	or Foreign
	Funeral Director			1□M 2 <b>X</b> F		4Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 1 – 1 1 –	y, Year) 41	MD	ountry)	
			Usual Residence of Decedent		100 City T									404 (124)	Oir Himbs
	show	ž	10a. State 10b. County		10c. City, T									10d. Inside	s 2 No
	the N	ect	MD  10e. Street and Number		Balt	lmor	10f. Zip	Code				10a Citiz	zen of What Co	.l	
	death with the Maryland ms 23e or 28a-f show rmat be netified at	<u></u>	624 W. Franklii	n St. A	pt. 4		212					USA			
	death	Funeral Director	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	13. V			spanic Orig	igin? (Spec	ify Yes or No ican, etc.)		4. Race - Ame		
٥	after or Ite		1X Never Married 2 ☐ Married	1 Yes 2			Tes,spec I∐Yes 2		Specify:		ican, etc.)		Black, White Specify Black		
12-0036	urel',	d by	3 Widowed 4 Divorced	Year or Dates											
	n 72	Completed	15. Decedent's E (Specify only highest gr	ade completed)		(Give	lent's Usua kind of woi DO NOT us	rk done d	uring most	t of working	g	16b. Kin	nd of Business	/Industry	
7 7	withi	omp	Elementary/Secondary (0-12) 9 th	College (1-4or		lursi		,				Hosi	pital		
land	be filed within 72 hours after death with the Maryla tal Hygiene. d other then "neturel", or Items 23e or 28e1's hovevent, I're Madical Examinar must be netitied at	BeC	17. Father's Name (First, Middle, Las.	0			<u>-</u>		18. Mothe	er's Name	(First, Middle,				
<u>a</u>		To E	Frank Wilson		_				Mari	e Ca	rroll				
Mar			19a. Informant's Name/Relationship		11								Town, State,	Zip Code)	
	1 and Health em 27		Patricia Pender	•						e. Ba	lto.		21216 cation - City or	Town State	
Baitimore,	0 0		1 XBurial 2 □ Cremation 3 [		·		sition (Nan natory or o						•		
			* 4 □ Donation 5 □ Other (Special Signature of Fundal Sende Lice		King		Mori			6-9-			imore, is Jr.		
n	permit. Departr Importe any inje		1/lelan	Char	1-						_		MD. 21		
г			23a. Part1. Enter the disease, or conshock, or heart failure. List only	aplications that cause	ed the death. [									Approxima Interval B	ate atween
	Physician		Immediate Cause (Final disease or condition	Acc	hus	ia	,							Onset and	
	/Medical		resulting in death)	Due to (or a	s a gon quen	ice of):									
	Examiner		Sequentially list conditions,	b	259										
	be tis	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or a	s a consequen	ice of):									
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g	tificate g phy as the	ledic									10				
ŏ	eath certific attending p	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy 2 DFetal de		Ectopic pr	egnancy				2	3d. Date of de		<b>V</b>
o o	e deal	Sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death		Other (sp						Month	Day	Year
7	hat the de d by the a letached	Phy	9 Winknown Part II. Other significant conditions	contributing to death	but not recultin	ag in the ur	nderkijna o	auco awa	n in Part I		23e Did t	obacco us	se contribute to	the cause of	death?
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ě	The law cate has page 2 t	Completed									autor perfo	rmed?	prior to death?	completion of	cause of
VItal		e Cc	25. Was case referred to medical						26 Place	of Death	1 🔼 Yes (Check only o	2 No	1/3-Yes	2 □ No	
	S S D	OB	examiner? 1 <b>∑</b> Yes 2 □ No	Hospital: 1 Inpat	tient 2 ER	/Outpatien	t 3 DO	Othe	ur.		e 5 ☐ Resid		Other (Spe	cify) at s	cene
n or	ng Ph Iter th neral	n: T	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of In	jury 28 lay Year)	b. Time of Injury		8c. Injury Work	at ?		d. Describe I	họw injury		A	
<u>0</u>	Mending death. ctor: Afte y the fun	catic	2 Accident investigation	U	05 FC	14) 5	o PM	1 🗆 Y	′es 21⊠1				1 0		
DIVISION	200	Certification:	3 Suicide 6 Could not determined	280. Place Of II	etc. (Specify)	e, rarm, str	eet, factory	r, office		28	3f. Location (3 City or Tov	Street and vn, State)	624 W	Frankli	n ST.
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	To the Hospitel or within 24 hours after To the Funerel Discompletely filled in	edical		miner: On the basis and manner	of examination										(s)
	To the within 2 To the complet	Me	29b. Signature and title of cortifier	MA			290	. License	number				signed (Mont		
ła.			XICA	XVV				OCM	E			June	5, 200	5	
			30. Name and address of person who	completed cause of	death (Item 23	Ba) (Type,		-	a a		D 7	3	36 -	1 01	201
			31. Date filed (Month, Day, Year)	7 HV	trar's Signature		111	Pen	n Str	eet	Ralti	nore,	Maryl	and 21.	ZUI
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_			For State Registrar			Cei	rtificat	e of L	Death			Reg. No.	100	10:	910
н	Physici	an	1. Decedent's Name (First, Middle,								2. Date of Dea Month JUNE 1,	2005	Year	3. Time of	
	/Medic	al	JEAN T. CARTE		thor)		4h City	Tours or	Location of	of Dooth	JUNE 1,		nty of Death	7 A.	М
	Examin	er	4a. Facility Name (If not institution, SASBURY METHODIS						RSBUR				ITGOME	DV	
-	Funeval				7. Age (In yrs.	last birthday)	If Under	1 Year	If Under		8. Date of Birt			place (State o	or Foreian
	Funeral Director		578-40-0091	1□M 2 <b>X</b> □F	96	Yrs.	Months	Days	Hours	Min.	JULY 9,	1908	MAR	YLAND	
			Usual Residence of Decedent				1								
	urytari show	_	10a. State 10b. County			y, Town or Lo								10d. Inside Ci	
	se Ma	cto		GOMERY	G <sub>f</sub>	AITHERS					·			1 ∑Yes	2[]NO
	I within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28e-f show the Medical Examinar must be notified at	Funeral Director	10e. Street and Number				10f. Zip					10g. Citizen o	of What Cou	ntry?	
	s 23e	rai	201 RUSSELL AVE		dant Consis II	6 10		877		-i-1/0-		USA	ann Amari	non Indian	
	er de item rer r	ņ	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie	12. Was Dece Armed For d 1 ☐ Yes	ces?	.5.	was Deced If Yes, spec	offy Cuba	n, Mexicar	gin? (Sp i, Puerto	ecify Yes or No- Rican, etc.)	14. H	ace - Americ lack, White,		
36	irs afi	by	3 ☐ Widowed 4 🌠 Divorced	If Yes, Give	8		1 ☐ Yes	X□ No	Specify:			Spec	city: WH	ITE	
Ö	2 hou	ted	15. Decedent's	Education		16a, Dece	dent's Usua	al Occupa	ation			16b. Kind of	Business/In	dustry	
215	within 7; ene. than "n	Completed	(Specify only highest Elementary/Secondary (0·12)	grade completed) College (1	-4or 5+)	(Give	kind of wo DO NOT us	rk done d se retired	during mos ()	t of work	ing				
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pu	be filec stal Hyg ed othe event,	Be (	17. Father's Name (First, Middle, La								e (First, Middle,	Maiden Sum	ame)		
yla	Ment Ment arke	ဥ	HARRY LYNN TAMM	ANY					ELL	A MA	E HALL				
Maryland 21215-0036	2 shot and le m	u y	19a. Informant's Name/Relationshi								al Route Numbe				
	ges 1 and 2 should it of Health and Mer if item 27 is marke or other traumatic			AUGHTER	20h F	3010 Place of Dispo			ILE K		BURTON Date	SVILLE 20c. Locatio	•		20866
Baltimore,	Pages nent of P nt: If ite iry or of		20a. Method of Disposition  1 Deurial 2 Decremation 3		State	emetery, crei	natory or o	ther plac							
턡	it. Partimer ritmer ritmit njury	. 4	'4 ☐ Donation 5 ☐ Other (Special Service Li		BA						3, 05 CK FUNE				
Ba	permit. Page Department of important: If any injury or once.		21.31.41.01.00	362							ROAD, LA		,		707
			23a. Part 1. Enter the disease, or c shock, or heart failure. List or	omplications that ca	used the deat								INFOR Y LI	Approximat	9
ı	Di est i	8 4	shock, or heart failure. List or Immediate Cause (Final	_		l l								Interval Bet Onset and I	
	Physician /Medical		disease or condition resulting in death)		or as a conseq		av	ac	eide	101			-	2 W =	ehs
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	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	c											
Ö,	be executed sician and burial-transit	Ex	resulting in death) Last	Due to (	or as a conseq	uence of):									
8760,	# × #	dicai		d		<del></del>						·			
x 68	eath certificat attending phy I for use as the	/Med	IF FEMALE:	23c. If yes, out	come of pregna	nev			- hallen in the						
Вох	attene for us	lan	23b. Was decedent pregnant in the past 12 months?	1☐Live bi	rth 2 ☐ Feta ant at time of d	Ideath 3	Ectopic pr						Date of delive Month	-	/ear
o.	that the de led by the a detached t	Physician/M	1 ∐ Yes 2 ☐ No 9 ☐ Unknown	9☐Unkno		eau J	1 Outer (sp	ocny/							
<u>α</u>	that ned b		Part II. Other significant condition	s contributing to de	ath but not res	ulting in the u	nderlying c	ause give	en in Part I.		23e. Did to	bacco use co	ntribute to t	he cause of d	eath?
Records,	The law requires that the death certifica tte has been signed by the attending ph bage 2 should be detached for use as th	d by	Isdremic	heart	dis	eare					1 🗆 Y	es 2 No	3 🗆 Prob	ably 4 🔲	Jnknown
00	aw requir s been si 2 should	Completed									24a. Was		. Were auto	psy findings	available
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Vital	sicien: T certificat rector, pa	Be C	25. Was case referred to medical						26. Place	of Deat	h (Check only o				
of V	d is y	10	examiner? 1 🗆 Yes 2 No	Hospital: 1 ☐ Ir	npatient 2	ER/Outpatier	nt 3□ DC	Othe	er: Nu	rsing Ho	me 5 Resid	ence 6 🗆 C	ther (Specif	<i>(y)</i>	
ם	fter	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Month	of Injury h, Day Year)	28b. Time or Injury		8c. Injury Work	c?		28d. Describe h	ow injury occ	urred		
Sio	Attending r death. ector: After by the fune	cat	2 Accident investiga 3 Suicide 6 Could no	t ho	-flature Ath		M		Yes 2□	-	20f Location /C	Stroot and Alive	nhoror Dire	- I Causto Africa	had
Division	or At after of Direction by	Certification;	4 ☐ Homicide determin	280. Place	of Injury - At he ig, etc. (Specif	y)	eet, ractory	, опісе			28f. Location (S City or Tow	n, State)	noer or Aura	a Houte Num	ber,
	spitel lours neral		29a. Certifier 1 Certifying	Physician: To the	best of my kno	wledge, deatl	h occurred	at the tim	ne, date an	d place,	and due to the o	ause(s) and	manner as s	tated.	
	ne Ho ne Fu	Medical	(Check only 2 Medical Ex	caminer: On the ba and mann	isis of examina	tion and/or in	vestigation	, in my op	oinion, dea	th occur	red at the time, o	date and place	e, and due to	o the cause(s	)
	To the Hospitei or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Σ	29b. Signature and title of certifier	n	* 0		290		number			29d. Date sign			
	1.		John L.	Mulm	ch	MI		D	1929	4		Jun	e 1,	2005	
	5		30. Name and address of person w	100			Print)	0	150//	1	Gait	1. 1	100	Ar	) 6
	8		31. Date filed (Month, Day, Year)	11/e/mi	egistrar's Signa	M)	711	144	I'CV	me	wait	ners ay	, ma	200	1
	Sta Registr	-	31. Date filed (Month, Day, Year)	2005	was L	k h	2000								
				- Janes	The Man	ASTA	14	***							

Sonia Chang 05-03780 NJM

-037 1	80		<b>1 - For Amend</b> Registrar Unper							d Mental Hy			189	17
			1. Decedent's Name (First	nd Item	23a,27,	28a-f	& Ce	rtificate of	f Death	2. Date of De	Reg. No.		3. Time of D	Death
	Physic /Medi		SONIA C	HANG						June	Day 2	Year 2005	0919	М
	Exami		4a. Facility Name (If not in					4b. City, Town,	or Location of De			ounty of Dea		
			9408 Owings						s Mills			altimo:		
	Funeral Director		5. Social Security Number 092-54-174	45 10	M 20 F	36	ast birthday) Yrs.	If Under 1 Year Months Day		1rs. 8. Date of Bi lin. (Month, D. 05/23	1969	9. Bin	hplace (State or yuntry) YORK	Foreign
5	and w		Usual Residence of Deced	dent County		10c. City	, Town or Lo	cation					10d. Inside City	Limite
	ith tha Marylar or 28a-f show e notified at	ctor		ALTIMO	RE			MILLS	5				1 Tyes 2	
	death with tha Maryland ms 23a or 28a-f show	Funeral Director	10e. Street and Number 9408 OWING	SS HEI	GHTS C	IRCLE	E	10f. Zip Code 211	.17		10g. Citize	on of What Co	ountry?	
	ter deat Itams	uner	11. Marital Status  1 X Never Married 2[		2. Was Deceder Armed Forces	3?	S. 13.	Was Decedent of f Yes, specify Cu	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No lerto Rican, etc.)	o- 14	Race - Ame Black, Whit		
0036	ural', or	þ	3 ☐ Widowed 4 ☐ Di	vorced	1 ☐ Yes 2 1 If Yes, Give Year or Dates	:		1□Yes 2MN	Specify:		S	рөсіfy: WI	HITE	
215-	hin 72 l	Completed		ecedent's Educ highest grade	completed)	. 5.1)	(Give	lent's Usual Occi kind of work don DO NOT use retir	e during most of v	working	16b. Kind	of Business/	Industry	
21	er the	Com	Liementary/Secondary (	0-12)	5+	3+/	CHE	MIST			BECT	ON D	CKINSC	N
Maryland 21215-0036	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Experiment must be notified at once.	To Be	17. Father's Name (First, M HIU CHANG	Middle, Last)					18. Mother's N	lame <i>(First, Middl</i> e CHANG	, Maiden St	umame)		
Mary	id 2 sho th and N 27 Is ma		19a. Informant's Name/Re				1			Rural Route Numb			Zip Code) S MILLS	5 21
	s 1 an f Heal item 2 other		20a. Method of Disposition	<u> </u>	<u>.</u>		ace of Dispo	sition (Name of	1	Date		tion - City or		, 21.
<u>=</u>	Page nent o ant: If ury or		1 ☐ Buriał 2 Crem '4 ☐ Donation 5 ☐ O	nation 3 ⊟Re ther <i>(Specify)</i>	emoval from State			natory or other pl CREMAT	ION 06	/11/05	HAME	STEAL	O,MD.	
Baltimore,	parmit. Departrimports any injury		21. Signature of Funeral S	ervice License	100		H	Name and Add	JENKI	NS & SO: MONKTON	NS CO	).		
3760, <	Physician /Medical Examiner	ical Ex	23a. Part1. Enter the dise shock, or heart failur Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Decase or mary that initiated events resulting in death) Last	C a	Undeter  Due to (or a  Due to (or a	mined s a consequ s a consequ	rence of):	er the mode of dy	ing, such as card	iac or respiratory a	rrest,		Approximate Interval Between Onset and De	en ath
P.O. Box 68	Attanding Physician: The law requires that the death cartificate b r death. crotath. ector: Atter this certificate has been signed by the attending physic by the funeral director, page 2 should be detached for usa as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregning in the past 12 months 1 ☐ Yes 2 ☐ No 9 ★ Unknown	ann	ic. If yes, outcom 1∐Live birth 4∐Pregnant a 9∐Unknown	2 Fetal	death 3	Ectopic pregnand Other (specify)	су		230	d. Date of deli Month	very Day Yea	ar
	uires that signed b Id be det	by	Part II, Other significant c	onditions cont	ributing to death	but not resu	lting in the ur	derlying cause g	iven in Part I.				the cause of dea	
I Recol	: The law require cate has been si, page 2 should t	Completed								24a. Was autor perio	rmed?	24b. Were aut prior to death?	topsy findings avaionpletion of cause	ailable se of
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to n examiner?		anital:					eath (Check only o	ne)			
Division of Vital Records,	vttanding Phys death. ctor: After this of y the funeral dir	ation; To	2 Accident	Pending investigation	28a. Date of Inj 28a. Date of Inj Found  6-2-05	ury ay Year)	R/Outpatient 28b. Time of Found 9:00	28c. Inju		Home 5 Resid		ther (Spec	ify) Scene unk	3
Divis	To the Hospital or Attandir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	Certification:	3 ☐ Suicide 6 <b>X</b> 4 ☐ Homicide	Could not be determined	28e. Place of In	njury - At hor etc. (Specify)	me, farm, stre	et, factory, office		28f. Location (S City or Tov Circle	Street and by yn, State) Owint	9408°01	vings He ls. Md	ight
	e Hospit 24 hour e Funera letely fills	Medical (	29a. Certifier 1 Ce (Check only 2 Me	ertifying Physi edical Examin	cian: To the bes	of examinati	vledge, death on and/or inv	occurred at the t estigation, in my	me, date and pla- opinion, death oc	ce, and due to the curred at the time,	cause(s) an	d manner as	stated.	
	To the within To the comp	M	29b. Signature and title of	certifier	4				se number CME	I .		igned <i>(Month</i>		
i	Jot pero	1	30. Name and address of p	PULA	IN ME			Print)	n Street	t Baltim	ore 1	Marvla	nd 21201	
	Sta Registr	te'	31. Date filed (Month, Day,	JN 0 7	2005 <sup>32. Red 8</sup>	trar's Signati	ure &	Joseph						-
		en a			1	April 111								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 6:22 AM M John De Vries June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Baltimore Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours 1 2 F Yrs. Director 217-38-0497 07/26/1927 Holland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County I Mygiene. other than "natural", or Items 23a or 28a-f ahow vent, the Wedteal Examinar must be notified at 1 Yes 2 No Director Baltimore Dundalk with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 death v 8171 Midhaven Road United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 5-0036 Specify: White 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland 2121 Automobile Elementary/Secondary (0-12) College (1-4or 5+) Salvage Inspector Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be nd 2 should be fi Ith and Mental H 27 is marked oth John De Vries Petersen Unknown 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Elizabeth De Vries /Daughter 8171 Midhaven Road Dundalk, MD 21222 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Jun 7 Department of Important: If any injury or once. ŏ Beltsville, Maryland 2005 Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MD0986 Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastatic Pnysician rear Colon disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ LAtern ( sclerasis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 🗆 No 1 Yes 21 No 1 TYes o the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier 29c. License number June 3, 2000 25205 no who completed cause of death (Item 23a) (Type, Print) Balt. N. Chranles St. md 2120x Bin( 6701 2. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 31 2005 ar **Physician** Menth 5 Ines Desmoineaux 3:30р м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14309 Ansted Rd. Silver Spring Mont gomery If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 8. Date of Birth (Month, Day, Year) 11-14-1925 9. Birthplace (State or Foreign Country)
Columbia 7. Age (In yrs. last birthday) **Funeral** Days 1□ M 2∰F Min Hours 214-48-5353 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "naturel", or Items 23a or 28e-f show the Medical Examinar must be notified at tx⊡xYes 2 □ No Director Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14309 Ansted Rd. 20905 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. snt: If item 27 Is marked other than "naturel", or Itel 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 XXYes 2□ No Specify: Columbian White þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Seamtress other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Tomas Solano Carman Higuera 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clara Santos (sister) 14309 Ansted Rd. Silver Spring MD 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ö 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Chesapeake Crematory 06-04-2005 Beltsville, MD 1 4 □ Donation 5 □ Other (Specify) 21. Signature of Funera 22. Name and Address of Facility Rapp Funeral & Cremation Service 933 Gist Av Silver Spring MD 20910 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Alzheimer's Disease 4 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) requires that the death certificate be executed attending physician and I for use as the burial-transit Cause (Disease or injur) that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Day Year Month 4□Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 🗆 No 1 ☐ Yes 2X No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 2 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) Certification: 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 X Matural 5 Pending M 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 0 06-01-2005 D0035045 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip G. Henjum 3416 Olandwood Ct. #204 Olney MD 20832 31. Date filed (Month Pay Year) 2005 Registrar's Signature State Registrar

			1 - For State Registrar	State of I	Marylan		artment o			Mental Hy	/giene	4000	18920
	Physici		Decedent's Name (First, Middle, La     PATRICIA ANN	•	Œ					2. Date of D Month June		y 2005 <sup>68</sup>	3. Time of Death 12:15 a M
	/Medic Examir		4a. Facility Name (If not institution, gir 7 Rose Street	e street and number	er)		4b. City, Tov Laure		on of Death	1	1	nne Ar	
	Funeral Director		215-36-3808	Sex 7. 1 □ M 2 □ F	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Y Months D	ear If Und ays Hour	der 24 Hrs. S Min.	8. Date of Bi (Month, D Apr 27	ay, Year)		Birthplace (State or Foreign Country) aryland
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23e or 28e-1 show any righty or other traumatic event, It's Marical Examinate to the Italia and once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ X ivorced	12. Was Decede Armed Force 1  Yes 24 If Yes, Give Year or Date	s? ZNo	'		of Hispanic Cuban, Mexi		pecify Yes or No Rican, etc.)		Black, W	merican Indian, hite, etc. Vhite
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Baltimore,	Pages 1 and nent of Heringt: If itam	1000	20a. Method of Disposition  1  Burial 2  Kremation 3  Other (Speci		te C6	metery, cren	sition (Name of natory or other idel Cr	place)	 	Date /2005			or Town, State  Maryland
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	Tot Tot	Σ	29b. Signature and title of certifier	es of	2100	W		ense numbe	r			te signed (Moi	nth, Day, Year) 2005
	Ŋ		30. Name and address of person who Marie Dobyns, M.D.		f death (Item 7ain Dus			te 3	LAur	el, MD	207	07	
	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 7 20	05 Regis	strar's Signatu	de de	le .						

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	• Physic	ian	1. Decedent's Name			'	-			-		2. Date of Dea Month		,	Year	3. Time o	f Death
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Maryland 21215-0036	be filed within 72 hours after death with the Maryland hal Hygiene. dother then "naturel", or Items 23e or 28e-1 show event. Its Medical Exam activities at	by Funeral	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed		12. Was Dece Armed For 1 Yes If Yes, Giv- Year or Da	2 <b>⊠</b> No e	'	Was Decedor f Yes, speci 1 ☐ Yes 2		spanic Ori n, Mexican Specify:	gin? (Spe 1, Puerto F	cify Yes or No- Rican, etc.)		14. Race Black Specify:	, White,	an Indian, etc. ite	
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Balt	permit. Pag Department Importent: I eny injury o		21. Signature of Fun	hony	Con	nel	les 7	110 S	വില	rs Po	oint	Home	Of Dund	Dur	ndal		A.
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8760,	cate be executed bhysician and the burial-transit	I Ex	resulting in death) La	ist	Due to (d	or as a consequ	uence of):										
87	icate b physic s the b	dical			d												
Вох 6	eath certific attending p for use as:	Physician/Me	IF FEMALE: 23b. Was decedent p	pregnant 2	3c. If yes, outo	come of pregna	incy _						2	3d. Date	of delive	rv	
Ď.	ne death the atte hed for	icia	in the past 12 m	nonths?	4□Pregna	rth 2 ☐ Fetal ant at time of de		Ectopic pre Other (spe				<del></del>		Mont		,	rear .
P.0	that the de ed by the detached	Phys	9 Unknown		9∐ Unkno					_		7	-1	-			
Division of Vital Records,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	by	Part II. Other signific	MROIDIS	M	ath but not resu	ulting in the ur	nderlying ca	use giver	n in Part I.		23e. Did to				e cause of d ably 4 ⊡L	
ec	e law has by ge 2 st	Completed	HYPER	EAR CEM	15							24a. Was a autops	SV	pr	ior to con	sy findings a	available ause of
a F	ate pag											perform 1 ☐ Yes	med? 2 No		ath? Yes	200 NO //	<u> </u>
Ξ		o Be	25. Was case referre examiner?	1.	fospital:	patient 2	ER/Outpatien	3 DOA	Other	~		Check on or				7	-
οί	g Phye	$\vdash$	27. Manner of Death		28a. Date of		28b. Time of Injury		c. Injury	at	rsing Hom 28	e 5 Reside Bd. Describe h				)	
Sion	Attending r death. ector: After by the funer	atio	1 Natural 2 Accident	5 Pending investigation	(INOTAL)	i, Day Youi,	mjury	М		es 2 🗆 1	No						
ĕ	or Att	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Płace o buildin	of Injury - At ho g, etc. <i>(Specif</i> y	ome, farm, stre	eet, factory,	office		28	Bf. Location (Si City or Town	treet and n, State)	i Numbei	or Rural	Route Numi	ber,
	spital ours a seral I		29a. Certifier 1	Certifying Phys	sician: To the l	hest of my know	wledge death	accurred a	t the time	data and	d place as	and also to the o					
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical	(Check only 2 one)	Medical Exami	ner: On the ba	sis of examinat	tion and/or inv	estigation, i	n my opi	nion, deat	h occurred	d at the time, d	ause(s) a ate and	place, ar	id due to	the cause(s)	)
	To the To the Comp	Me	29b. Signature and ti	tle of certifier				29c.	License	number		2	9d. Date	signed	(Month, E	Day, Year)	
}	(		Ing	francisco				2	22	488	2		6.	- 5	-0	5	
	iΧ		30. Name and address	ss of person who co	Mipleted cause	of death (Item)  22 gistrar's Signal	23a) (Type, 8	Print)	T A	EDAN	: Ba	(AMO	OZ	K1	90	1210	
	≝ Sta	te	31. Date filed (Month		32 Re	gistrar's Signat	ture	A DE	ic y	1		11110		1116	~/	10/0	
	Registr	ar	11	IN 0 7 200	15	we to	x Got										

			1 - For State of N	faryland / Depa	artment of He			giene Reg. No. 005	18922
	Discount of		Decedent's Name (First, Middle, Last)				2. Date of De		3. Time of Death
	Physicia /Medic		Benilda Maria Delgado				MAY	30 th 200	
	Examin		4a. Facility Name (If not institution, give street and number	7)	4b. City, Town, or			4c. County of De	ath
			Lorieh Nursing Home	and the second second	Columbia If Under 1 Year	If Under 24 Hrs.	0.0	Howard	2.4. (2
	Funeral Director		216-98-3099 1□M 2☐¥F	ge (In yrs. last birthday) 82 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da 11-26	-22 Par	Birthplece (State or Foreign Country) nama
	and w		Usual Residence of Decedent  10a, State 10b, County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Manyl f sho	0	MD	Laurel,	MD				1 □ Yes X □ No
	the 128e	rect	10e. Street and Number	_ Laurer,	10f. Zip Code			10g. Citizen of What	Country?
	3a ou		10004 Woodland Walk		20723			USA	
	deetl	ner	11 Marital Status 12. Was Deceder	t Ever in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No	14. Race - Ar Black, W	merican Indian,
õ	or Ite	Fu	Armed Force  1 Never Married 2 Married  1 Yes, Give	No	Yes 2□ No				ispanic
ğ	ural',	d b	3 Widowed 4 Divorced Year or Dates			Specify: Panama	anian		
21215-0036	filed within 72 hours after deeth with the Maryland Hygiene. the than atteral, or tlems 23s or 28e-1 show ant, the Modical Examiner mast be notified a	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occupa kind of work done di DO NOT use retired)	ition uring most of work	ing	16b. Kind of Busine	ss/Industry
7	d within	d L	Elementary/Secondary (0-12) College (1-4o	r 5+)	maker			Home	
7 0	e filed value of Hygie other vent, II	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle	, Maiden Surname)	
Maryland	0 to 0	To B	Martin Delgado		N	Maria Ba	arrios		
a <sub>Z</sub>	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street a.	nd Number or Run	al Route Numb	er, City or Town, State	, Zip Code)
	and 2 ealth a n 27 I		Rosemary Sher (Grandda					urel,MD	20723
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other ance.		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place	9)	Date	20c. Location - City	or Town, State
Ě	Pages ment of lant: If it		` 4 ☐ Donation 5 ☐ Other (Specify)	MD. Nat				Laurel,M	
ă	permit. Departs Imports any inj once.		21. Signature of Funeral Service Licensee				_	havis Jr	
	70 F # 0		misley many					to. MD 2	
			23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	line.	ter the mode of dying	g, such as cardiac	or respiratory a	irrest,	Approximate Interval Between Onset and Death
-	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	CVA					days
	Examiner		Due to (or a	is a consequence of):					1 2
		-e	Sequentially list conditions, if any, leading to immediate b. Due to (or a	is a consequence of):					
	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (blease of the party that initiated events)						
o Î	exec an an rial-tr	Exa		is a consequence of):					
8760	certificate be executed ding physician and ise as the burial-transit	dlcal	d						
9	ndiffica ng ph a as tl	0	IF FEMALE:						
Box	death certific te attending pl ed for use as t	Physician/M	23b. Was decedent pregnant 1 Live birth	2 Fetal death 3	Ectopic pregnancy			23d. Date of a Month	delivery Day Year
O	0 0	yslc	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant 9 ☐ Unknown 9 ☐ Unknown		Other (specify)				·
<u> </u>	law requires that lhe as been signed by th 2 should be detache		Part II. Other significant conditions contributing to death	but not resulting in the u	ınderiying cause give	n in Part I.	23e. Did 1	tobacco use contribute	to the cause of death?
ecords,	uires tha signed l	d by					10	Yes 2□No 3□	Probably 4 driknown
Ö	w requir been si should I	Completed					24a. Was	an 24b. Were	autopsy findings available
Ř	0 - 0	шc						psy prior to ormed? death	to completion of cause of ?
Vital	sicien: Th certificate irector, pag	0	25. Was case referred to medical			26. Place of Deat	1 ☐ Yes	2 No 1 Y	es 2 No
	S S	OB	examiner? 1 ☐ Yes 2 ☐ Ne Hospital: 1 ☐ Inpa	tient 2 ER/Outpatie	nt 3 DOA Othe	NP:		idence 6 Other (S	pecify)
ז סל	ding Ph	n: T	27. Manner of Death 28a. Date of Ir Natural 5 ☐ Pending (Month, I	jury 28b. Time o	of 28c. Injury Work	at	28d. Describe	how injury occurred	
000		atlc	2 Accident investigation			res 2 □No			
Division	or Attendater deatl	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e. Place of building,	njury - At home, farm, st etc. (Specify)	reet, factory, office		28f. Location ( City or To	Street and Number or wn, State)	Rural Route Number,
	urs al					<u> </u>			<u> </u>
	To the Hospitel or Att within 24 hours after d To the Funerel Direct completely filled in by i	edical	29a. Certifier  (Check only one)  Certifying Physician: To the be 2 Medical Exeminer: On the basis and manner	of examination and/or in					
	To t To t	Σ	29b. Signature and title of certifier	47	29c. License			29d. Date signed (Mo	
			Som	- T D	D00.	53150		JUNE 15	t 2005
			30. Name and address of person who completed cause o	death (Item 23a) (Type	DOO. Print) SANT	10000	An S	UITEIIO	BIA 21045
	0		Shakunmara Gup-			ri QU PL		COLUM	BIN CIONS
	Sta Registr		31. Date filed (Month, Day, Year)  31. Date filed (Month, Day, Year)  31. Date filed (Month, Day, Year)	strar's Signature	and I				

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8923 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Death Dey Physician Year Τ. Ernest Dousha 2005 June /Medical 11:55 AM 4a Fecility Neme (If not institution, give street end number) 4b. City. Town, or Locetion of Deeth Examiner 4c. County of Deeth Future Care of the Chesapeake <u>Arno</u>ld <u>Anne Arundel</u> If Under 1 Year If Under 24 Hrs. 6. Sex 1 2 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Yrs. Director 213-07-7795 Usuel Residence of Decedent 91 Apr. 13,1914 Maryland permit. Peges 1 end 2 should be filed within 72 hours after deeth with tha Maryland Depertment of Heelth end Mentel Hygiena. Important: if item 27 is marked other than "natural", or itema 23s or 28s-f show any lajury or other traumatic event, the Madical Examinat must be notified at once. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 No Director Maryland Anne Arundel Glen Burnie 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 899 South Shore Drive Funeral U.S.A. 14. Race - American Indian, 21060 Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Š 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 N/ALoftsman Beth. Steel Corp 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Ernest Dousha Matilda 19a. Informent's Name/Relationship (Type, Print) (Daughter)

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Diane M. Procter (Niece) 395 Ironwood Court Millersville, Maryland 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 6/4/05 Brooklyn Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) ementia URal Examiner Due to (or as a consequence of) Examine signed by the attanding physician end d be datached for usa as the buriel-transit requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown à 24b. Were autopsy findings available prior to completion of cause of deeth? been si Completed 24a. Was an autopsy performed? certificata 1 ☐ Yes 3 No 1 ☐ Yes 2 No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 \_2 DX 1 ☐ Yes this funerel 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation n 24 hours efter death.

Funeral Director: At bletaly filled in by the fu death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, efc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide Hospital 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. Medical To the Hosp within 24 hou To the Fune completaly fi (Check only one) re and title of certifier 29b. Signat 29c. License number 29d. Date signed (Month. Day, Year) 5072 2005 30. Name end eddress of person who completed cause of deeth (Item 23e), (Type, Print) tuy M. Worsville, MD 21108 860 RUNITERK 12 dinger 31. Date filed (Month, Day, Year) 32. Degistrer's Signature State JUN 0 Registrar

			1 - For State Registrar	State of	Marylan	d / Depa		t of H	ealth and I	Mental Hy		05	18924
	Physici		Decedent's Name (First, Middle, Last)     Marcella				Doers	on		June 2		Yeer	3. Time of Death 4 P M
	/Medio Examir		4a. Facility Name (If not institution, give s 714 McKnew Road	treet and num	ber)		-	Town, or mbri	Location of Death			nty of Death Arund	el
	Funeral Director		210-20-0702	M 2 <b>∑</b> F	7. Age (In yrs. 78	last birthday) Yrs.	If Under Months	1 Year Days	Hours Min.	8. Date of Birtl (Month, Day Feb • 17	, 1927	9. Birthp Coun Kent	place (State or Foreign htty) Lucky
	anyland show	<u></u>	Usuel Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo						1	0d. Inside City Limits 1 ☐ Yes 2√0XNo
	the M	recto	MD Anne Aru	nder		Gambr	10f. Zip	Code			10n Citizen	of What Coun	- 177
	h with	i Di	714 McKnew Road				1.0,,2.6		054		_	JSA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any futury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deced Armed For 1 Tes 2 If Yes, Give Year or Da	ces? 2 📉 No		Vas Deced f Yes, spec		spanic Origin? (Sp. Mexican, Puero Specify:	pecify Yes or No- Rican, etc.)		Race - Americ Black, White, cify:	
Maryland 21215-0036	ithin 72 ho ne. nen "netur Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		4or 5+)		kind of wor DO NOT us	k done d e retired,	luring most of wor	king		f Business/Inc	,
2	Hygier Hygier ther th	Cor	12 17. Father's Name (First, Middle, Last)			Perso	nnel	Clei	18. Mother's Nam	ne (First Middle			rernment
ryland	nould be f d Mental I narked or natic eve	To Be	Joseph Heath	on Orient		405 Mallia		/211	Ed:	ith Dern	bach		
	ulth and 27 is n		19a. Informant's Name/Relationship (Ty) Paul A. Doerson (		d)				oad, Gaml				Code)
Baltimore,	Pages 1 au ent of Hea nt: If item ry or othe		20a. Method of Disposition  1  Burial 2  Cremation 3		20b. P	lace of Disposemetery, crem	sition (Nam natory or of	ne of ther place	9)	Date / 2005	20c. Locatio	on - City or To	wn, State
Balti	permit. Departm Importa any Inju		21. Signature of Funeral Service License	all	1	22	. Name and	d Addres	s of Facility Funeral Ly Avenue				+O1
3760, /	Ambierian and Inspection and Inspect	Icai Examiner	23a. Part1. Enter the disease of complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (o	used the death ch line.  + ous + t  r as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of a consequence of as a consequence of a conseq	uence of):			a, such as cardiac L to h		est,		Approximate Interval Between Jonset and Death Comments of the
.O. Box 68	Attending Physician: The law requires that the death certificate be executed redeath. The fall the restricted has been signed by the attending physician and ector. After this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 my hths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		th 2 ☐ Fetal nt at time of de	death 3	Ectopic pre					Date of delive Month	ry Day Year
О.	quires that n signed by	by	Part II. Other significant conditions con	tributing to dea	ith but not resi	ulting in the un	iderlying ca	iuse give	n in Part I.			ontribute to th	e cause of death?
Records,	The faw require ate has been si page 2 should t	Completed								24a. Was a autops perform	SV	prior to con death?	osy findings available npletion of cause of
/ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?						26. Place of Dea	h (Check only or	10)		
Division of Vital	nding Physi th. : After this c funeral dire	ition; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1  ln 28a. Date of (Month		ER/Outpatient 28b. Time of Injury		3c. Injury Work	r: 4 □ Nursing Ho at ? 'es 2 □ No	ome 5 Reside 28d. Describe he			)
Divis	F air c	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building	of Injury - At ho g, etc. (Specify	me, farm, stre	et, factory,	office		28f. Location (Si City or Town	treet and Nut n, State)	mber or Rural	Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edicai C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the been continued in the base and manner	is of examinal	wledge, death tion and/or inv	occurred a estigation,	at the time in my op	e, date and place, inion, death occur	and due to the cred at the time, d	ause(s) and ate and plac	manner as sta e, and due to	ated. the cause(s)
)	To the within To the comp	Me	29b. Signature and title of certifier  Mulew	۱.۵.				License				13/05	
	10		30. Name and address of person who con Young J. Lee	-20	of death (Item	23a) (Type, F Hano)	Print) IER	St.	54413 Balt	imore	MD	2122	25
	Sta Registr	1100	31. Date filed (Month, Day, Year)	10	nietrar'e Signa								

State of Maryland / Department of Health and Mental Hygiene | 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 1000 AM Julia 4,\_ P. 2005 Demski June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2915 Delmar Avenue Edgemere Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Months Days Hours Min. 1 M 2 X F Yrs Director 218-01-1109 June 26,1921 Maryland Usual Residence of Decedent with the Maryland 10a, State show 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "neturel", or Items 23e or 28a-f shov treumetic event, It. M. Alc. Exertiner must be rollined at 1 ☐ Yes 2 No Maryland Baltimore Direct Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2915 Delmar Avenue death Funerai 21219 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status nours after ☐ Yes 2∑ No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: ð If Yes, Give Year or Dates: Specify. 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 72 } 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within tent of Health and Mental Hygiene. nt: If item 27 is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Inspector Steel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Pazdzinski Margaret Polen 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Bernadine Watkins 1048 Middleborough Road Essex, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State ö permit. Page Department of Importent: If any injury or once. 5 Other (Specify) ⁴ 4 □ Donation Sacred Ht. of Mary Cem. 6/7/2005 Dundalk, Maryland 21. Signatur Funeral Service License 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear tailore. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Cancer DVarian 3mos disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner burial-transit be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physician/Medical d IF FEMALE: If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 2∏ No of Vital 1 Yes 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: ဂ္ 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 6 □Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Division To the Hospitel or Attending 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 3 🗍 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funeral [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D39660 June 6, 2005 Wheta 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Robert-Durt Rd. Baltimore which 31. Date filed (Month, Day, Year) 2009 istrar's signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 0742 A M Liam Richard Diedrich May 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Yrs Director May 23, 2005 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "neturel", or items 23a or 28a-f show the Medical Examiner must be notified at Director MDAnne Arundel SevernaolPark 1 ☐ Yes 2√ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 323 North Drive 21146 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after ☐Yes Z☐No Yes, Give 'ear or Dates: Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Š 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wire Department of Health and Mental Hygient Importents: If item 27 Is marked other thus any injury or other traumatic avent, Iffall 2006. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be IInknown Pamela Joy Diedrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Joy Diedrich (Mother) 323 North Dr. Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial X☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 6/2/2005 Baltimore, MD 21. Signature of Funeral Se 22. Name and Address of Facility Hardesty Funeral Home P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Enysician 9119 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death cartificate be exacuted Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Wasan autopsy performed? (es 200 No 1 ☐ Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient ۵ 3□ DQA this Aftar thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Annupolis, 2001 31. Date filed (Month, Day, Year) 32. Registrar's Sgnature State JUN 0 7 2005 Registrar

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State of Marylan	nd / Department of H	ealth and Me	ental Hygien	-

			1 For State Registrar  1. Decedent's Name (First, Middle, La.)	State of Ma			artment of F			Reg. No.	105	18921
	Physic		Jackson Robert	Diedrich					Month May	Day 25	2005	3. Time of Death
	/Medi Examii		4a. Facility Name (If not institution, given Anne Arundel Med		r		4b. City, Town, o	r Location of Dea		4c. Cc	ounty of Death	<u> </u>
	Funeral Director			9x 7.Age	e (In yrs. last birt	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min 20 6		Year)	9. Birthp Coun	lace (State or Foreign stry)
	land w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Lo	cation					Od. Inside City Limits
	Mary 1-f sho	to	Maryland Anne An	rundel	Severna						,	1 ☐ Yes 2√☐ No
	death with the Maryland ms 23a or 28a-f show I must be notified	Director	10e. Street and Number		<u></u>		10f. Zip Code			10g. Citizer	of What Coun	
	s 23a	ral	323 North Drive	10.111.0		1	2114				USA	d
215-0036	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or Itams 23a or 28a-f show event, Ita Medical Examinat must be notified at	by Funeral	11. Marital Status  12 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1  Yes 2  M If Yes, Give Year or Dates:	ever in U.S.		Vas Decedent of H f Yes, specify Cuba □ Yes 2 XNo	ispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		Race - Americ Black, White, o Pecify: White	etc.
<u>ہ</u>	72 ho	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a.	Deced (Give	ent's Usual Occup	ation during most of wo	rkina	16b. Kind	of Business/Ind	lustry
_	within 72 ene. than na'	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. L	OO NOT use retired	1)	9			
B	Hygid other	Be Co	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle,	Maiden Sui	mame)	
yland		To B	Unknown					Pamela	Joy Died	rich	·	
Mar			19a. Informant's Name/Relationship (7) Pamela Joy Diedri						ural Route Number			Code)
ָט ע	1 and Health am 27 ther tr		20a. Method of Disposition	(Mothe)	100		NOTED Dr.	, Severn	na Park,			
Ē	Page ent o nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery	y, crem	ematory of other place	· 1			on - City or Tov more, M	
Dall	permit. Departm Importal any inju		21. Signature of Funeral Service Licer				Name and Addres	4.5	rdesty F			
	90 E 5 9		78-1.0	M-		1	12 Ridge	ly Ave.	Annapoli	s, MD	21401	F • A •
			23a. Part1. Enfer the disease, or composhock, or heart failure. List only of	Ications that caused one cause on each lin	the death. Do no e.	ot ente	r the mode of dyin	g, such as cardia	or respiratory arr	est,		Approximate Interval Between Onset and Death
F	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Extra	consequence o	P	emat	arity				1 day
	Examiner		0.000	Due to (or as a	consequence o	i): \	\-	- ab				4 6
	sit se	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	e to (or as a	cons uence o	f):	i war	34414	1			11113
	xecute and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of	f)·						
000	uncate be executed g physician and as the burial-transit	edical		d.	•	,						
9	ing phy	Medi	IF FEMALE:							- 1021-		
	v requires that the death cer been signed by the attendin should be detached for use	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 ☐ Fetel death		Ectopic pregnancy			23d.	Date of deliver	•
	y the g	nysic	1 Yes 2 No 9 Unknown	4□Pregnant at t 9□ Unknown	ime of death	5 🗌	Other (specify)				MONIN L	Day Year
	ns that gned b e deta	by Pt	Part II. Other significant conditions co	ntributing to death but	t not resulting in	the un	derlying cause give	n in Part I.	23e. Did tob	acco use c	ontribute to the	cause of death?
5	w require been sig should b								1 ☐ Ye	s 212 No	o 3 ☐ Proba	bly 4 🗆 Unknown
2	e 2 sh	Completed							24a. Was ar		b. Were autops	sy findings available pletion of cause of
3	oning rnystcian: the law h. After this certificate has b funeral director, page 2 s		75 W.						perform		death? 1 ☐ Yes 2	
	y sicia s certi directo	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:	t 2 ER/Out	antiont	3□ DOA Othe		th (Check only one			
5	ig Priya ter this neral di	T:uc	27. Manner of Death	28a. Date of Injury (Month, Day	28b. Tir		28c. Injury Work	4 🗆 Nursing 🗖	ome 5 Reside			
5	leath. lor: Afi the fur	catlc	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	7 027	ury		es 2 □No				
	after of Direction by	Certification;	4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm (Specify)	n, stree	et, factory, office		28f. Location (Str City or Town	eet and Nu State)	mber or Rural I	Route Number,
	hours meral y filled		29a. Certifier 1 Certifying Phy	sician: To the best of	my knowledge,	death (	occurred at the time	a date and place	and due to the ca	use/s) and	manner ac etal	
1	To the propriet of attending Prysician:  To the Euneral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medical Exami	ner: On the basis of e and manner state	skammation and	or inve	stigation, in my op	inion, death occur	rred at the time, da	te and plac	e, and due to the	he cause(s)
ļ	To To Som	Σ	29b. Signature and title of certifier	010	4-		29c. License		29	d. Date sig	ned (Month, Da	ay, Year)
	1		Duran 1	dela	- DO			1733	m	Vace	25.	2005
			30. Name and add of person who co	empleted use of dea	ath (Item 23a) (T	уре, Р	rint)			0		
	Sta	-	31. Date filed (Month, Day, Year)	32. Ragistrar	's Signature							
	Registra		JUN 0 7 20	105 Stages	e St.	A STATE OF THE PARTY OF THE PAR	ed s					
нΜ	H 17 Rev 1/20	101				-	0.00					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Robert Joseph Emmitt June 2005 2:01 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2905 McComas Ave. Kensington Montgomery If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 € M 2 □ F 70 526-40-8150 Yrs. Director Feb. 2,1935 Ohio Usual Residence of Decedent iled within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it e Modical Examinar must be notified at Maryland Montgomery Director Kensington 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2905 McComas Ave. 20895 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 ₩ Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Education Specialist Federal Government  $5\pm$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be fi and Mental D. Emmitt Lillian Bartkowski 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s nent of Health an item 27 David A. Emmitt / Son 2905 McComas Ave., Kensington, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Chesapeake Crematory 6/8/05 Beltsville, MD Rapp Funeral and Cremation Services 20910 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** VXIATION disease or condition resulting in death) /Medical Due to or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d, Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the been signed by the should be detach Part IJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 X esidence 6 ☐ Other (Specify) 2 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; After 1 Natural June 5, 2005 1 ☐ Yes 2 XNo phyxiation 2 Accident investigation Director: 6 Could not be determined 3 Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) City or Town State)

1 C C M AS + VE KENSIN TO 28f. me Kensing on Mi 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical within 2 To the 29d. Date signed (Month, Day, Year) atricia Name and address of person who completed cause le Pike, Suite G-100 Rockville, MD 2085 10mg 31. Date filed (Month, Day, Year) State 7 JUN 0 Registrar

			1 - For State of Maryland / Depar Registrar Certification	rtment of Health and Nificate of Death		ne N2 0 0 5	18929		
	Physici /Medio Examir	al		4b. City, Town, or Location of Death	2. Date of Death Month	Day Year O 2005 4c. County of Death	3. Time of Death  5 40 qM		
	Funeral Director		Stella Maris           5. Social Security Number         6. Sex         7. Age (In yrs. last birthday)           219-03-4288         ₩ 2 F         83         Yrs.	Timonium  If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yo Aug. 31	Baltimor 9. Birthplac Country MD	ce (State or Foreign		
ore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If flame 21s marked other than "natural", or Itams 23s or 28s-f show any injury or other traumatic avant, the Medical Frantmer must be rollined at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loca  MD Baltimore Timonium	n	100	10d	Inside City Limits  1 ☐ Yes 2 ☐ No		
			10e. Street and Number  2525 Pot Spring Rd. Unit L506  11. Marital Status 1 □ Never Married 2 ◯ Married 1 ◯ Never Married 2 ◯ Married 1 ◯ Never Married 2 ◯ Married 1 ◯ Never Married 2 ◯ Married 1 ◯ Never Married 2 ◯ No	as Decedent of Hispanic Origin? (Spreas, specify Cuban, Mexican, Puerto		USA  14. Race - American Black, White, etc	Indian,		
			3 ☐ Widowed 4 ☐ Divorced   If Yes, Give 144-146   1 L	☐ Yes 2 ☐ Yeo Specify:  Int's Usual Occupation  Ind of work done during most of work  O NOT use retired)	king 16I	Specify: W b. Kind of Business/Indus	hite <sub>stry</sub>		
			17. Father's Name (First, Middle, Last)	fied Public Accounts 18. Mother's Name Edna [	e (First, Middle, Mai	Civil Service iden Surname)	e		
			19a. Informant's Name/Relationship (Type, Print)  Alberta Anne Eidman/wife  2525  20a. Method of Disposition  20b. Place of Disposition	Address (Street and Number or Run Pot Spring Rd. tion (Name of tatory or other place)	Unit L506		MD 2109		
Baltimore,	permit. Pag Department Important: I any injury o		'4 □ Donation 5 □ Other (Specify) Balto. Was	sh. Crematory 6/ Name and Address of Facility Emmon Funeral H W. Padonia Rd.		Laurel, MD ulaney Valle um, MD 2109	y, Inc.		
	Physician /Medical		23a. Part 1. Ent the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	the mode of dying, such as cardiac	or respiratory arrest	. A	pproximate Iterval Between Inset and Death		
	To the Hospital or Attending Physician: The law requires that the death certificate be exacuted within L24 hours fair death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely fitted in by the funeral director, page 2 should be detached for use as the burial-transit in	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as a consequence of):						
		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ E 4 □ Pregnant at time of death 5 □ C	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Da	ay Year		
		by	Congestive Heart Failure 1040s				2 No 3 Probably 4 Unknown  24b. Were autopsy findings available		
		Be Completed	25. Was case referred to medical	26. Place of Dea	24a. Was an autopsy performed 1 Yes 2 Xes	d? prior to complete death?	letion of cause of		
		ပ္	1 ☐ Yes 2K No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  28c. Injury at Work?  M 1 Yes 2 No					
Division		Medical Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)						
			29a. Certifier ty Certifying Physician: To the best of my knowledge, death of Check only one)  2 Medical Examiner: On the basis of examination and/or investant and manner stated.		red at the time, date		e cause(s)		
5	+17		30. Name and address of person who completed cause of death (Item 23a) (Type. Pr ERNESTINE WRIGHT, M.D. 2300 DULA	rint)  ANEY VALLEY ROAD	TIMONIU	UM MD 210	193		
Í	Sta Registr		31. Date filed (Month, Day, Year) JUN 0 7 2005	,					

DHMH 17 Rev 1/2001

EIDMAN, HENRY

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Enon 2005 May 1010 am Hannah 31 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Northwest Hospital Randallshown Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 F 70 N/A 03-13-1935 Director Africa Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show ir than "natural", or items 23a or 28a-f show The Medical Examiner must be notified at 1 ☐ Yes 2 PNo **Funeral Director** Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8521 Glen Michael Lane Apt 202 21133 Africa filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Treasurer Finance Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If item 27 is marked other t jury or other traumatic avent. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Enohmba Frida Nyapechu 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Apt 202 19a. Informant's Name/Relationship (Type, Print) Comfort Ako 8521 Glen Michael Lane Randallstown, Md 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 06-26-2005 Cameroon, Africa Cameroon \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundral Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors Inc 8728 Liberty Road Randallstown, Maryland 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerotic Cardiovascular Dseule -Enysician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, any, leaving to important cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 mounts? Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, entensi 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ nknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2 No 1 Yes 1 Tyes Hospital or Attending Physician: Alter this certification, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No EN/Outpatient 1 Inpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier eller mo may 31, 2005 D0058141 Wendie Williams, mp 50. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wilndie S401 Old Court Road Randall Stown MD 31. Date filed (Month, Day, Year) Registrar

For State Registrar			1 _ State	State of Maryland / Department of Health and Mental Hygiene 005  Certificate of Death					18931	
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	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	2005	pour l	A PORT			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** unv Arthur David Foley May 27, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Dey, Year) Aug. 9, 19 **Funeral**  Birthplace (State or Foreign Country) 1<del>∏</del>M 2□F Months 374-07-1174 85 T919 Director Massachusetts Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exampler mant be notified at MD 1√2 Yes 2 No Montgomery Chevy Chase Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5600 Wisconsin Avenue, NW 20815 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of health and Mental Hygiene.
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any or other traumatic event, the Madical Exam any 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If #es, Give 1941-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1945 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. State Dept. Elementary/Secondary (0-12) College (1-4or 5+) Diplomat 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Foley Rose Foley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Foley, daughter 8901 Mt. Lassen Avenue, Vancouver, WA 98664 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 6/1/05 permit. Page Department of Important: If any injury or once. injury or Beltsville, MD Chesapeake Crematory ' 4 ☐Donation 5 ☐ Other (Specify) Rapp Funeral and Cremation Services 933 Gist Avenue Silver Spring, MD 21. Signature of Funeral Sen Me0382 Stephen Hollmann 20910 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician SEPSIS /Medical Due to (or as a consequence of): Examiner DIFFICILE COLITIS CLOSTRIBIUM Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: ner attending physician and for use as the burial-transit death certificate be executed Exami CARDIOHYOPATHY SCHEMIC Due to (or as a consequence of) Box 68760 Completed by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ned by the a P.O. 9□ Unknown 9 Unknows The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 Yes Physiclan: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🛕 No 2 filled in by the funeral 27. Manner of D ath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: al or Attending F s after death. Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital within 24 hours a To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 20.08.		21. Signature of Funeral Seryi Lice	1//	00773					aldson , Laure		al Hom 2070	ne, P.A. 7
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1		Gregory H. Fishe		15225 Sha		re Ro	ad, G	Gaith	nersbur	q, MD		
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			For State Registrar	State of Maryland	Certificate of I		Reg. No	ZUUD	18934
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	Funeral Director		5. Social Security Number Link 6. Sex	7. Age (In yrs. la	Ast birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dal, Year, 5   5   7 ()	9. Birthpla Countr	Ce (State or Foreign
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Baltimore,	permit. Pages 1 a Department of Hee Important: If itsm any injury or othe		21. Signature of Funeral Service License	Pokuns	Sterling 736 Edmon	Ashton S	chwab Funer	ral Home,I	nc.
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	be is	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as'a consequ	ence of): 🤍				,
	be executed ician and burial-transif	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequ	ence of):				
760,	te be executed ysician and te burial-transit	caiE							
289	ificate g phy as the								
Box	death certificat e attending phy d for use as th	In/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal		,		23d. Date of delivery	
	deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de 9☐ Unknown				Month D	ay Year
P.O.	at the	by Physician/Medi	9 Unknown		Nine is the underbine as use our	ag in Dart I	23a Did tobacco	use contribute to the	cause of death?
Ś	The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the		Part II. Other significant conditions con	tributing to death but not resu	iting in the anderlying cause giv	en in Faiti.	1 ☐ Yes 2		
Vital Record	neen hould	Completed							
Rec	e la has	mpi					24a. Was an autopsy performad?	prior to com	sy findings available pletion of cause of
la		e Co	25. Was case referred to medical			26 Place of Dea	1 ☐ Yes 2 ☐ No th (Check only one)	1 ☐ Yes 2	□ No
>	Physician: rthis certific ral director,	To B	examiner?	ospital: 1 Inpatient 2 🗆 E	ER/Outpatient 3 DQA Oth	or	ome 5 Residence	6 ☐Other (Specify)	2-7/
οl	g Ph ter th		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury Wor	y at k?	28d. Describe how inju	iry occurred	
Sior	endin aath. or: Af	atic	1 Natural 5 Pending 2 Accident investigation			Yes 2 □ No			
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, street, factory, office		28f. Location (Street at City or Town, State	nd Number or Rural i e)	Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical Co	29a. Certifier 1 Certifying Phys	ician: To the best of my know er: On the basis of examinati	vledge, death occurred at the tir ion and/or investigation, in my o	me, date and place, pinion, death occur	and due to the cause(s	and manner as stand place, and due to the	ted. he cause(s)
	To ths H within 24 To ths F complete	Medi	one)  29b. Signature and title of certifier	and manner stated.	29c. Licens			ate signed (Month, Da	
	To With		250. Signature anormal of certiner	leannts la	Such Du	5/15		/ - / .	•
•			30. Name and address of person who con	noleted cause of death (Itam	23a) (Typer Drint)	0.	1-3/	5.72000	2
			100/100 Residence	16 2 2 3 E	of St Fail	Place	Balti	31/2025 more h	ND.
	Sta	te	31. Date filed (Month, Day, Year)	37 Registrar's Signat	yre South				
	Registr		HIN A 7 2005	British St	Ag				

		·	1 - For State Registrar		of Marylan		artment of H		Mental Hyg	eg. No.	)5	189	35
Н	Physici	an	1. Decedent's Name (First, Midd	lle, Last)	FO	Ide	0		Month	Day	Year	3. Time of 9:06 a	M
	/Medic		4a. Facility Name (If not institution	on, give street and		,,,,,	4b. City, Town, or	r Location of De	05 ath	4c. County	005 of Death	0.00 0	
	Examili	er	, , , , , , , , , , , , , , , , , , , ,	3432 Spell				Ва	ltimore		N/	A	
	Funeral	===	5. Social Security Number	6. Sex	7. Age (In yrs.	• • •	If Under 1 Year Months Days	If Under 24 H		Year)	9. Birthp	lace (State or	r Foreign
L	Director		220-22-6153	1 □ M 2 <b>½</b> □ I	85	Yrs.			Jan 14			Ś. C.	
	and w		Usual Residence of Decedent  10a. State 10b. Count	у	10c. City	y, Town or L	ocation				1	0d. Inside Cit	y Limits
	Many!	ō	Md	N/A			Ва	altimore				1 🖄 Yes	2 🗆 No
	28a-	rect	10e. Street and Number				10f. Zip Code		1	0g. Citizen of	What Cour	itry?	
	h with	Die	3432 Spellman Roa	ad				21225			U.S.A	ι.	
	ems 2	ner	11. Marital Status		ecedent Ever in U. I Forces?	S. 13.	Was Decedent of H	ispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		ce - Americ		
36	or It	y Fu	1 Never Married 2 Ma	rried 1 TY	s 2 No Give					Specif		Black	
21215-0036	72 hours after death with the Maryland natural; or Items 23a or 28a-f show disal Examiner must be natified at	Completed by Funeral Director	3 XWidowed 4 ☐ Divorce	nt's Education	or Dates:	16a Dece	dent's Usual Occup	ation		16b. Kind of B			
7.	in 72 n "na nadic	piet	(Specify only high	est grade complet		(Give	kind of work done of DO NOT use retired	during most of w	vorking			,	
212	e filed within 7 al Hygiene. I othar than "r vent, It a Mad	mo	Elementary/Secondary (0-12)	Colleg	e (1-4or 5+)		Hous	sekeeper		P	rivate In	dustry	
미	al Hy d othe	Be C	17. Father's Name (First, Middle					18. Mother's N	lame (First, Middle,				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Importants if item 27 is marked othar than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examinal must be notified at any injury or other traumatic event, the Madical Examinal must be notified at ance.	10		Dick Nelson		T				Jane Bias			
Mar	12 sh h and 7 Is m traum		19a. Informant's Name/Relation  Annette Moore Da				•		Rural Route Number	-	, State, Zip	Code)	
	1 and Health em 27 ther tr		20a. Method of Disposition	agniei	20b. P	lace of Disp	osition (Name of			20c. Location	- City or To	wn, State	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		om State	-	matory`or other place . Zion Cemete	1	06/06/05	La	nsdown	e. Md.	
ij	nit. Partme ortan injur.		21. Signature   Fundament Service		110	-	2. Name and Addres		00,00,00			-,	
B	permi Depa Impo any ir	l	Commen !	Ach	Melle	4	Estep B	rothers Fur	neral Service F Baltimore, Md	A 21217			
I Re	Pnysician /Medical		23a. Parvi. Enter the disease, shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	on each line.	OVas	ter the mode of dyin	ng, such as card	iac or respiratory arr	est,		Approximate Interval Betv Onset and D	ween
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discass of high) that initiated events	b. Due	to (or as Jused	vence of):	tens, s	100				109	rs
68760,	death certificate be executed e attending physician and of for use as the burial-transit		resulting in death) Last		to (or as a conseq	uence of):							
.O. Box	that the death certifics ed by the attending ph detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Unknown	1 ☐ Li 4 ☐ Pi	outcome of pregna ve birth 2 Peta regnant at time of d nknown	I death 3	□Ectopic pregnancy □ Other (specify)	<i>'</i>			te of delive onth	•	/ear
rds, P	sign sign d be	by	Part II. Other significant condi	tions contributing	to death but not res	ulting in the t	underlying cause giv	ren in Part I.	23e. Did to	bacco use con es 2	tribute to th		leath? Jnknown
Il Records,	The law ate has b page 2 sl	Completed							24a. Was a autops perfor 1 ☐ Yes	med?	Were auto prior to co death? 1  Yes	psy findings a mpletion of ca 2 No	available ause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medic examiner?	al Hospital:			at all DOA Oth	.00	eath (Check only or				
of	Phys rthis ral di	T.	1 Yes 2 No	28a, D	ate of Injury	ER/Outpatie	111 3 DOX	4 🖂 IAMISING	Home 5 Resid		ner <i>(Specif</i> red	r)	
O	tanding Ph leath. tor: After th the funeral	tion	1 Natural 5 ☐ Pend	/1	Month, Day Year)	Injury	Wor	k? Yes 2 ☐ No		,			
Division	or Attanding after death. Diractor: After in by the fune	fica	3 ☐ Suicide 6 ☐ Coul	d not be 28e. P	lace of Injury - At he	ome, farm, si	reet, factory, office		281. Location (S		ber or Rura	I Route Numi	ber,
Ö	al or A s after of in b	Certification:	4 Homicide	Ь	uilding, etc. (Specif	y)			City or Tow	n, State)			
	To the Hospital or At within 24 hours after of To the Funeral Dirac completely filled in by	edical C		I Examiner: On the					ace, and due to the courred at the time, o				)
	To the within 2 To the complet	ž	29b. Signature and title of certif	ier )			29c. Licens	e number		9d. Date signe	d (Month,	Day, Year)	
•	K		1 2 800				146	005 4	351	61	1/2	005	
1	2 1		30. Name and address of person		cause of death (Item	1 23a) (Type	, Print)		- Woods		mi	7.20	_
1	Sta		31. Date filed (Month, Day, Yea	7 2005	2 Degistrar's Signa	3250 Iture	starting (	sate Li	- Woods	INE !	/Id	2179	7
	Regist	ai	JUNU	1 2000	Willes &	C 15	ALC: NO.						

			For State Registrar		State o	f Marylar		artment rtificate				lental Hyg	giene 0	05	18936
	Dhysisi	<b></b>	1. Decedent's Name	e (First, Middl	e, Last)							2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physici /Medio				NN GERAGH		ESTER					June 4	2005		12:00P M
	Examir	ier			n, give street and nu	mber)				Location	4		D. 1.	ty of Death	
			BROADME 5. Social Security N		6. Sex	7. Age (In yrs.	last hirthdayl	If Under		svil	Le 24 Hrs.	8. Date of Birt (Month, Day Jan 13,	ватт	1more	County
	Funeral Director		213-20-1		1□M 2√F	82		Months	Days	Hours	Min.	(Month, Day	, Year) 1923	Cou	place (State or Foreign intry)
ı			Usual Residence of			- 02						Juli 15	, 1/23	⊥ Mar	:yland
	rylan how	_	10a. State	10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
	Ba-f s	cto	Maryland		more Coun	ty	Cock	eysvi							1 ☐ Yes 2 ₹ No
	ath with the Marylan s 23a or 28a-f show	Director	10e. Street and Nur		1 0 1			10f. Zip		2102	0		10g. Citizen o		intry?
	s 236	rai		ancewo	od Road	edent Ever in U	18 12	Mac Doord		21030		acifu Vac or No		USA	ican Indian,
	ter dea	Funeral	11. Marital Status  1  Never Marri	ied 21⊽7 Man	Armed Fo	orces?	13.	f Yes, spec	ify Cubai	n, Mexicai	n, Puerto	ecify Yes or No- Rican, etc.)	BI	ack, White,	
900	urs aft	þ	3 ☐ Widowed			ve X		1 ☐ Yes 2	X No	Specify:	:		Spec	ify: [	√hite
Č	72 hours "natural",	Completed	(Spac		it's Education st grade completed)			dent's Usua kind of wor			st of work	ina	16b. Kind of	Business/Ir	ndustry
5	ithin and	nple	Elementary/Seco	<del></del>	College (	1-4or 5+)	life.	DO NOT us	e retired,	)		9	М-	1: - 1	
Š	IIIQ X IX 13-0030 be filed within 72 hours after death with the Maryland tall Hygiene. id other than "natural", or items 23e or 28e-f show event, I'm Medical Exertiliar mather rollified at		17. Father's Name	/Eiset Middle		yrs	Regi	stere	a Nu		or's Name	e (First, Middle,		dical	
October Manufacture Act of the Ac	Maryiano Z 1 Z 1 nd 2 should be filed within lith and Mental Hygiene. 27 Is marked other than " r traumatic event, the Mer	To Be	James Jo		Geraght	У				10. 1410(14		ra Frock			
5	Taryid 2 should and Men Is marke aumatic		19a. Informant's Na	ame/Relations	ship (Type, Print) (	Husband	A.	_				al Route Numbe			
12	and and m 27				ester, Jr										land 21030
2	D des 1		20a. Method of Disp 1 X Burial 2		3 □Removal from	State 20b.	Place of Dispo cometery, crea	natory or of	ne of ther place	θ)		Date	20c. Location	- City or T	own, State
	t. Partmen		° 4 ☐Donation	5 Other (S	Specify)		odlawn				6/8/2				Maryland
$\frac{1}{2}$	Dalilliore, Wi permit. Pages 1 and 2 Department of Heelth a Importent: If Item 27 is any injury or other fra anges.			Mal X	awson	~						Funeral			The second secon
0					r complications that conly one cause on	caused the deat	th. Do not ent	500 Y er the mode	ork of dying	Road g, such as	, Ba.	Itimore, or respiratory ar	, Maryl rest,	and _	21212 Approximate
	Physician		Immediate Cause	(Final	only one cause on e	each line.	220								Interval Between Opset and Death
	/Medical		disease or condition resulting in death)	in	a. Due to	(or s a consec		$n_{I\partial}$	<u> </u>						IWK
	Examiner	L	Sequentially list co if any, leading to in	nditions.	b										
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7/0	ate be executed thysicien and the burial-transit	dicai E													
U	o g tt	ledic													
7 0	eath certific attending p	an/N	IF FEMALE: 23b. Was deceden			tcome of pregna		DEctopic pre	agnancy					ate of deliv	,
3	b deal he att	Physician/Me	in the past 12 1 Yes 2	DNO		nant at time of c		Other (spe					N	lonth	Day Year
136	The Loud was, F. C. BOX of The Industries that the death certific the has been signed by the attending page 2 should be detached for use as:	Phy	9 Unknown		ons contributing to d		culting in the u	ndorhina os	nico aivo	n in Dart I		23e Did to	hacco use co	Thute to t	the cause of death?
2 0	signe d be c	d by	()°	steo	BUTYOSI.	<	anning at the t	naony ing oc	1030 g.10	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1 🗆 Y	/		bably 4 □Unknown
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Tal An der	The lav	Completed	1-		71710	[ /	<i>t</i>					autop perfor	med?	death?	opsy findings available ompletion of cause of
\$ 5		Ble Co	25. Was case refer			Orve	<u>S</u>			26. Place	of Defath	1 ☐ Yes	2 <b>DN</b> o	1 🗆 Yes	2 L No
200	Attending Physician: r death. sctor: After this certification the funeral director, by	To B	examiner?	No	Hospital:	Inpatient 2	ER/Outpatier	it 3 DO	A Othe	er .	/	me 5 ☐ Resid		ther (Specif	fy)
			27. Mann of Deat	h 5 □ Pendir	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28	Bc. Injury Work	at ?		28d. Describe h	ow injury occu	irred	
7	Witendia death. ctor: Aly y the fu	catic	2 Accident	investi	gation not be			М		res 2□	-				
	f or Atten after deat Director:	Certification;	3 Suicide 4 Homicide	determ	ined 200. Place	of Injury - At hing, etc. (Specil	ome, farm, str fy)	eet, factory	, office			28f. Location (S City or Tow		iber or Rura	al Route Number,
6	Hospitel 14 hours a Funerel I tely filled	Ce	29a. Certifier	15 Certifyir	ng Physician: To the	hest of my kno	wledne death	occurred a	at the tim	e date an	nd place	and due to the c	ause(s) and a	nanner as s	stated
(5)	To the Hospital or A within 24 hours after To the Funeral Direction completely filled in b.	edical	(Check only one)	2 Medical	Examiner: On the b	asis of examina ner stated.	ation and/or in	vestigation,	in my op	pinion, dea	ith occurr	ed at the time, o	late and place	, and due to	o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and	title of certifie	or /		11 71	29c.	License	number		2	29d. Date sign	ed (Month,	Day, Year)
			1 10a	rba	ra la	roll	L, M	9	DI	383	92		Col	6/6	2005
	M	2	30. Name and addr	ess of person	who completed caus	se of death (Iter	n (Type,	Print)	71	11.	701	777	( )		27030
	0		31. Date filed (Mon	th. Day Year	MKKO	Registrar's Signa	ature )	138	UI	YO	KK	KD.	WKI	=1/5/	METIND
	Sta Registr		JUN		47	) A	1-1								_
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State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Margaret Frankenberg 9:28 a May 28, 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Ellicott City Howard Millenium Health & Rehab Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 F Director 037.24.4373 May 22, 1904 Scotland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Item 27 is marked other than "naturel", or Items 23e or 28e-f show other traumatic event, the Medical Exemities must be indiffed at 1 ☐ Yes 3 ☐ No Directo Maryland Ellicott City Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21043 U.S.A permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nature" any injury or other traumatic acceptance. 3000 North Ridge Roaf by Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) own home Elementary/Secondary (0-12) College (1-4or 5+) homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elizabeth Waugh 2 William Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2640 S. Veitch Street; # 108 Arlington, Virginia 22206 Ms. Debra A. Frankenberg Daughter-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 06/06/2005 Baltimore, MD \* 4 ☐ Donation \* 5 ☐ Other (Specify) **Bayview Crematory** 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MyoborDist Priysician /Medical Condivious al Distore A theoseles fri Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine for use as the burial-transit that initiated events resulting in death) Last ed by the attending physician and detached for use as the burial-tran death certificate be execu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown The law requires that the After this certificate has been signed by funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗷 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Injury at Work? 1 3 Natural 5 Pending 2 🗌 No death. 1 Yes investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D the Hospitei 29a. Certifier Æ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature, and title of certifier MAy 28 2005 16arm D34951 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tkaczuk, Edmund P., MD 405 frederick Road, Suite 100 Baltimore, MD 21228 31. Date filed (Month, Day, Year) State JUN 0 7 2085 Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 3. Time of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month Dev Year **Physician** Ida Μ. George 8:17P.M. 05 05 25 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street and number) Examiner Montgomery Chevy Chase Manor Care Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Deys Hours 1 M 2 TF 93 Yrs. 579-03-2580 Washington, D.C. Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 1 X Yes 2 □ No Chevy Chase Director MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 20815 8700 Jones Mill Road USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 E No If Yes, Give Yeer or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritel Status 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Specify: Black δ 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Philadelphia Housing Elementery/Secondary (0-12) College (1-4or 5+) 2 yrs. <u>Administration Assistant</u> Authority 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Richmond Milton Ella Diggs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jean M. Millard/Sister 558 Ingraham St. N.E. Washington, D.C. 20011 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriel 2 □ Cremation 3 □ Removal from State Lincoln Memorial 6 - 3 - 05Suitland, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MArshall's Funeral Home 4217 9th. St. N.W. Washington, D.C. 20011 Ma 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Due to (or as a consequence of): Physician/Medical Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events Due to (or as a consequence of): Hypertension Due to (or as e consequence of): resulting in deeth) Last Atrial Fibrillation 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4X Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 XNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 3 DOA ို 2 ☐ ER/Outpetient 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Death Certification: Injury 5 Pending 1 XNaturel 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated edicai 29a. Certifier 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture and title of certifier 5-25-05 D-20274 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Dr. Kirti Vohra, M.D. 7710 Bradley Blvd. Bethesda, MD. 20818 31. Date filed (Month, Day, Year) Registrer's Signature State JUN 0 7 2005

DHMH 16 Rev 6/95

Registrar

**Funeral** 

Director

permit. Pegas 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mentel Hygiene. Important: If fen 27 is marked other than "natural", or frame ??

**Physician** /Medical

Examiner

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	Examin	er	4a. Facility Name (If not institution, gir Saint Josep	re street and number)  The Medical	Center	4b. City, Town, or	Location of Death	vson	4c. County of I	Baltimore
	Funeral Director			Sex 7. Age (	In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.			Birthplace (State or Foreign Country)
	pug *		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryla	to	MARIANO HARF		Bill	1. R				1 ☐ Yes 2 ☐ No
	th the or 28a e coli	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	t Country?
	s 23a		SSS SOUTH ATL	12. Was Decedent Ev	APT 119	310	14	anifu Van as Na	V.S.	American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show any njury or other traumatic event, Item Medical Examination that the Colling at 2006.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	Specify:	Rican, etc.)		White, etc.
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ılan	uld be Mental Irkad Itic ev	To B	2 NOTERIZ	DAVID En	H 2, 181		Witc	RED S	SOZOZK	SR
lar)	2 sho and ! is ma		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street a	and Number or Ru	ral Route Number	City or Town, Sta	te, Zip Code) 3116
	1 and Health Bm 27 thar t		20a. Method of Disposition	221	20b. Place of Dispo	sition (Name of	BUHIO	Date	20c. Location - Ot	y or Town, State
Baltimore,	ages ent of i nt: If its y or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Spec	Removal from State	cemetery, crei	matory or other place	27	7,	501 E V	DARMANN W
붍	mit. Postme		21. Signature of Funeral Servi & Lice		- BEL A:	2. Name and Addres	ss of Facility	1991-1	BELAIR, A	The Party of the P
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	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		DGENIC S	HOCK				4 DAYS
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<u>α</u>	w requires that been signed b should be deta		Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did tol	1	te to the cause of death?  Probably 4 Unknown
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ion	nding ath. r: Afte e fune	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day )	rear) Injury	M 1	k? Yes 2 □No			
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	To the within To the comp	M	29b. Signature and title of certifier	1401	MM	29c. Licens	e number	2	9d. Date signed (A	Month, Day, Year)
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	12	The state of the s	30. Name and address of person who				17 20 4			
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	Registi		JUN 0 7 200	5 Blacker.	S Signature					

			For	State of Maryland	-			ntal Hygi	ene	1001.0
			State Registrar  1. Decement's Name (First, Middle, La	etl	Certif	icate of Death		Reg	g. No.	3. Time of Death
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	/Medic Examin		4a. Facility Name (If not institution, give			. City, Town, or Location of	of Death	J 0,13	4c. County of Dea	ath
4			7217 Old Har 5. Social Security Number 6.5	tord KO. Sex 7. Age (In yrs. las	t birthday) If	Under 1 Year   If Under	24 Hrs. 8	Date of Birth	9 Bi	rthplace (State or Foreign
	Funeral Director			1□M 20 F		onths Days Hours	Min.	Date of Birth (Month, Day,	Year) J. Pu	erto Rico.
ī	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, 1	Town or Locati	on				10d. Inside City Limits
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	death with the Maryland rms 23a or 28a-f show r must be notified at	Funeral Director	10e. Street and Number	-0 1 01		Of. Zip Code	1	10	g. Citizen of What C	ountry?
	leath w	erai	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was	Decedent of Hispanic Ori	igin? (Specif	v Yes or No-	14. Race - Am	erican Indian.
٥	after o		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Decedent of Hispanic Ori s, specify Cuban, Mexican Yes 2 No Specify:	$\cap$	án, etc.)	Black, Wh	
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Бант	permit. Pages Department of Importent: If is any injury or o		21. Signature of Funeral Service Lice	11.64.1	22. No	me and Address of Facility	BALI	MORE	mo 2	1234.
n	20E 29		23a. Part 1. Enter the disease, or con	1. gat/acting	EVA	NSFUNERA	HC4	APEL 8	3800 HARI	Approximate
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X O O	death certificate e attending phys d for use as the	in/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance		opic pregnancy			23d. Date of de	*
р Э	ie deat the attr hed for	Physician/Med	in the past 12 Months?  1  Yes 2 No 9  Unknown	4☐ Pregnant at time of deat		ner (specify)			Month	Day Year
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on or	ttending Ph death. stor: After th the funeral		27. Manner of Death  1 X Natural 5 Pending	(Month, Day Year)	8b. Time of Injury	28c. Injury at Work?  M 1 Yes 2		d. Describe hov	v injury occurred	
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	,		200 Name and address of person who	my, m D.		D 224 8	88		6-5.0	5
	6		30. Name and address(of person who	completed cause of death (Item 2:	3a) (Type, Prir	NBRIDGE,	ROND	: BAG	TMORE, A	10. 2/2/2
	Sta	_	31. Date filed (Month, Day, Year)	39. Registrar's Signatur	θ					3
	Registr	ar	JUN 0 / 20	Desire Si	AND ST					

Registrar

31. Date filed (Month, Day, Year)

JUN 0

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egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201

JUNE

3, 2005

	1	For State Registrar		State of N	larylar		artmen rtificat					giene ()	05	18942
<b>♦</b> .		. Decedent's Name (First, N	fiddle, La	ast)							2. Date of Dea	ith Day	V	3. Time of Death
Physiciar /Medica Examine		Djamshid a. Facility Name (If not instit	ution, gi		Guiv		4b. City,	Town, or	Location	of Death	June 1,	2005	Year inty of Dea	12:47 P M
Funeral Director	5	Prince Georg Social Security Number	e 's	General H	ospit	a1 last birthday) Yrs.	Che	ver1			8. Date of Birth (Month, Day Oct. 19	Pring Year)	oce G	eorge 's  thplace (State or Foreign ountry)
the Maryland 28e-f ehow	1	Jsual Residence of Deceder  Oa. State 10b. Co  Maryland Pri	unty	George's		y, Town or Lo								10d. Inside City Limits 1    Yes 2   No
28e-1	1	0e. Street and Number	-			11060	10f. Zip	Code				10g. Citizen	of What Co	21
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-1 ehow any injury or other treumatic event, the Modical Eventing must be notified at once.	2	1 Marital Status 1 Never Married 2 X 3 Widowed 4 Divo	Married	Park Driv  12. Was Deceder Ammed Force: 1Yes If Yes, Give Year or Dates	nt Ever in U s? No	.S. 13.	2	0740 dent of Hi		gin? (Sp	ecify Yes or No- Rican, etc.)	14. F	ran	encan Indian, e, etc.
21215-0036 ed within 72 hours ati ggiene. er then "neturel", or it, the Modical Event	- mileted		ighest gi	ducation ade completed) College (1-4o	r 5+)	16a. Deced (Give life.	dent's Usua kind of wo DO NOT u	rk done o	turina mos	t of work	ring	16b. Kind o	f Business	/Industry
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Div after 1 Dire	5	4 Homicide	rigiti i i i o		etc. <i>(Specil</i> Home	(y)					6100°We	stanes	ster I	?ark Dr.#612
Hospi 4 hou Funer ely fill				hysician: To the bearing and manner	st of my kno of examina							ause(s) and	manner as	stated.
To the within 2 To the complet		29b. Signature and title of ce	rtifier				290	c. License	number		2	9d. Date sig	ned (Mont	h, Day, Year)
		Aulor	ado	VL	lost	ن في		H00:	55927			June 3	3, 200	05
11	1	30. Name and address of per	rson who	completed ause of	death (Iter	n 23a) (Type,	Print)		-					
•		Salvador Sy					ital	Dr.,	Chev	verly	, Maryl	and 20	785	
State Registra		31. Date filed (Month, Day, )  JUN 0 7			strar's Signa	door	0							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registre Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 10.25 PM **Physician** 2005 06 m 8 05 /Medical 4a. Fecility Name (If not institution, give street and number)
Good Samaritan Hospital 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore, MD If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 K Yrs. 130-14-498 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f ahow other traumetic avant, the Medical Examiner must be notified at TY Yes 2 □ No Director Shomi LARD Chellord 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ŏ Itams 23a 31366 Completed by Funeral 3312 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 11. Marital Status ☐ Yes 2 Yes, Give 1 Never Married 2 Married 9 Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced ZIHU Year or Dates: "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ls marked ပ SHEEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If itam 27 Is any injury or other tratones. Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition TE Burial 2 Cremation 3 Removal from State \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signa ure of Funeral Service Licenses 31334 MULLE ROPY 18RY LAM 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Preumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical as the b IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No jo 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknown by 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 3 Probably 4 □Unknown obstructive 1 ☐ Yes 2 ☐ No pulmonary Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 1 Yes Division of Vital Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No P his funeral 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After t Certification: 5 Pending investigation 1 TYes 2 No death. 2 Accident Diractor: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a To the Funarel E 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

DHMH 17 Rev 1/2001

7

Registrar

RES 000

good Sanaritan Hospital 5601 Loch Raven Boulevard

Baltimore

June 5th, 2005

MD

m.D

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

I. MUKHERJEE

31. Date filed (Month

JUN 0 7 2005

			For 1_ Stata	State of Maryland /	Depa		lealth and M	Mental Hyg	iene	•	18944
	fig		Registrar  1. Decedent's Name (First, Middle, Last)		Cer	lilicale of	Dealli	2. Date of Dea	leg. No. th		3. Time of Death
	Physici		RHONDA			(	ZRAY	JUNE	Day 02	2005	9:20 PM
	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, o	r Location of Death		4c.	County of Deal	
		·.	JOHNS HOPKINS HOSP	ITAL		BALT	IMORE			N/A	
	Funeral Director		218-56-1793	7. Age (In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day 9-23-1	952	9. Birt Co MAR	thplace (State or Foreign ountry) YLAND
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tov	vn or Lo	cation					10d. Inside City Limits
	Mary f sho	tor	MD. N/A	BAT.	TIMO	RE					1 ☐ Yes 2 ☐ No
	n the	Director	10e. Street and Number			10f. Zip Code			l0g. Citíz	zen of What Co	ountry?
	23a c	ralD	137 N. CURLEY ST.			212			US		
36	be filed within 72 hours after death with the Maryland hal Hygiene. od other than "natural", or items 23a or 28a-f show avant. The Medical Examinar must be Indilled at	by Funeral	11. Marital Status  1 ⚠Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Pes 2 No If Yes, Give Year or Dates:	1	Vas Decedent of H Yes, specify Cuba Yes 2X No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- p Rican, etc.)		4. Race - Ame Black, Whit Specify:	
9	2 hou	ted	15. Decedent's Educ	ation 16a	a. Deced	ent's Usual Occup	pation	kina	16b. Kir	nd of Business	/Industry
215	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)			during most of wor. d)	King			
21	filed with Hygiene. other than		-12-	-0-	BENE	FITS OFF		ne (First, Middle,		CIAL SEC	CURITY
Baltimore, Maryland 21215-0036	should be fi ind Mental H is marked ott umatic avar	To Be	17. Father's Name (First, Middle, Last) THEROCIOUS GRAY				THELI	MA HYTHE			
Mar	s 1 and 2 should f Health and Men itam 27 is merke other traumatic	4	19a. Informant's Name/Relationship (Typ TERES GRAY (DAUGHT			-	and Number or Ru. ${ m TOGA}\ { m ST}$ .				
ē,	Heall Heall tam 2		20a. Method of Disposition	20b. Place of	of Dispo	sition (Name of		Date		cation - City or	
OE	@ O .	ľ	1 ☐ Burial 2 ☐ Cremation 3 ☐ Re  1 ☐ Donation 5 ☐ Other (Specify)	KTN	G ME	natory`or other plac MORIAL P	ARK 6-8-	2005	BAL	TIMORE	, MARYLAND
Balti	perr it. Page Dep rtment of Imp rtant: If any injury or		21. Signature Fin ral Service License	FOTOMBMENT CIN	BNEF	Name and Addre	ss of Facility PH	ILLIPS F	UNER	AL HOM	È, P.A. ARYLAND 2121
	Physician	(2. V)	23a. Part. Enter the disease, or complic shock or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the death. Do cause on each line.	not ente	er the mode of dyir		or respiratory arr	est,		Approximate Interval Between Onset and Death 24 months
	/Medical Examiner		resulting in death)	Due to (or as a consequence	of): (	I	5.5				ī. <i>Ji</i>
		Examiner	Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a consequence	ILE off.	yphropa	Thuy	20.			U MoiAh5
, 09/	eath certificate be executed attending physician and for use as the burial-transit	cal Exa	that initiated events resulting in death) Last	Due to (or as a consequence	of):						
68	rtificat ng phy s as th		IF FEMALE:								
O. Box	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as tr	Physiclan/Med	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 No 9 □ Unknown	<ul> <li>ic. If yes, outcome of pregnancy</li> <li>1 □ Live birth 2 □ Fetal death</li> <li>4 □ Pregnant at time of death</li> <li>9 □ Unknown</li> </ul>		Ectopic pregnancy Other (specify)	<i>'</i>		2	3d. Date of dei Month	livery Day Year
Vital Records, P.O.	luires that i n signed by ild be deta	by	Part II. Other significant conditions cont	ributing to death but not resulting	in the ur	nderlying cause giv	ren in Part I.				o the cause of death?
CO	aw requir is been si 2 should I	Completed						24a. Was a		24b. Were au	utopsy findings available completion of cause of
R	The lavate has	Com						perfor	med?	death?	2 No
/ita	sician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?					th (Check only or			
o	hys his	은	1 ☐ Yes 2 ☑ No ☐ HG  27. Manner of Death 1 ☒ Natural 5 ☐ Pending	ospital: 1 Inpatient 2 ER/O 28a. Date of Injury (Month, Day Year)	Time of Injury	28c. Injur Wor	er: 4 □ Nursing H y at rk? Yes 2 □ No	ome 5 Resid			city)
Division	al or Attanding P after death. I Director: After t d in by the funera	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Płace of Injury - At home, f building, etc. (Specify)	arm, str			28f. Location (S City or Tow			ural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Directonpletely filled in D	Medical C		ician: To the best of my knowledger: On the basis of examination a and manner stated.							
	To the within To the comp	Me	29b. Signature and title of certifier	MD-PhD		29c. Licens				signed (Mont	
			> Manne				ES - 00	U	Ju	me 02	2,2005
	6		30. Name and address of person who cor THAO NGUYEN, MD PH	D, JOHNS HOPKIN	s He	SPITAL,	600 NORT	H WOLFE	STRE	ET, BALTI	MORE MD 21287
	Sta Registi		31. Date filed (Month, Day, Year) JUN 0 7 2005	32. Registrar's Signature	dos	We .					

			1 - For State Registrar	State of Maryland	•	nent of Healt			ene 1. No. 20	05	18945
	Physici	an	1. Decedent's Name (First, Middle, Last)					. Date of Death		Year	3. Time of Death
	Physici /Medi		PAUL O. HONAK					Month		Year 2005	1458 M
	Examir	ner	4a. Facility Name (If not institution, give st KERNAN HOSPITAL	reet and number)		City, Town, or Loca ALTIM (2)			4c. County	of Death	
b	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday) If L	Inder 1 Year   If Ur		Date of Birth (Month, Day, )		-	ce (State or Foreign
	Director		282.44. 1550 10K	M 2 F 57	Yrs. Moi	nths Days Ho	ours Min.	(Month, Day, Y	147	Countr	OH
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City.	Town or Location	1				100	d. Inside City Limits
	Maryl -1 sho	tor	MD NA		TIMORE						1 KYes 2 □ No
	h the	Funeral Director	10e. Street and Number	0,12		f. Zip Code		100	g. Citizen of W	hat Countr	y?
	ath wit	ralD	110 S. ROCK GLEN	J ROAD		21229				USA	
	er de:	nue		2. Was Decedent Ever in U.S Armed Forces?	i. 13. Was 0	ecedent of Hispani specify Cuban, Me	ic Origin? (Specif exican, Puerto Ric	y Yes or No- can, etc.)		- Americai k, White, et	
920	urs aft	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ØSYes 2 ☐ No If Yes, Give Year or Dates:	1□Y	es 2 <b>15</b> No <i>Spe</i>	ecify:		Specify:	BUL	2K
5-0036	within 72 hours after death with the Maryland sne. then "neturel", or Items 23c or 28e-1 show to Modical Exeminer mast be nutified an	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Decedent's	Usual Occupation	most of working	16	6b. Kind of Bu	siness/Indu	stry
2121	within iene. then "	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	ANALYS	of work done during OT use retired)			EDERA	1 (	OVT.
	filed y Hygie other 1	e Co	12.7H GRADE  17. Father's Name (First, Middle, Last)	NA	MIORETS	•	Mother's Name (F				OVT.
lan	ould be Mental arked o	To B	PAUL HONAKER :	SR.		_	ROTHY	GREEN		,	
Maryland	2 should and Men is marke eumatic	_	19a. Informant's Name/Relationship (Typ	e, Print)		dress (Street and No	umber or Rural P	Route Number, (	City or Town,	State, Zip C	Code)
_	and lealth m 27		RAGENIA MARTIN	(DAUGHTER)	USS.R	OCK GLE				212	29
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23s or 28e-1 show any injury or other treumatic event, If e Medical Exeminar must be multiled at any injury or other treumatic event, If e Medical Exeminar must be multiled at anong.		20a. Method of Disposition  1 ■ Burial 2 □ Cremation 3 □ Re	moval from State	metery, crematory	or other place)	Dale	111	c. Location - 0	•	
Ħ	artme ortent injury		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service License</li></ul>		RISON F		06.10.		NINGS		LS, MD
B	Depa Impo any ir		Naugh_ C		VAUG	HN C. GRE BAUD. NATI	CENE FUN	VERAL S BAUTO : Y	no 2	1229	
	* *		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death.						le le	Approximate nterval Between
	Pn <del>ysicia</del> n /Medical		Immediate Cause (Final disease or condition resulting in death)	PULMON	ARY	EMBOL	ISM				Onset and Death
	Examiner		- 1	PLASMACY		OF THE	= SAC	RUM			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):		2011	2011			
	ecutec and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	DEBIUT							
8760,	The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit		Todaling in dodality basis	Due to (or as a conseque	ence or):						
687	ificate g phys as the	Physician/Medical	d.						4-		
Вох	leath certifica attending ph I for use as th	M/us	230. Was decedent pregnant	c. If yes, outcome of pregnand 1□Live birth 2□Fetal o		oic pregnancy			23d. Date	of delivery	
О. В	the att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of dea 9☐Unknown		r (specify)			Mon	th D	ay Year
P.	res that the digned by the be detached		Part II. Other significant conditions cont	ributing to death but not result	ting in the underly	ing cause given in P	Part I.	23e. Did tobar	cco use contri	bute to the	cause of death?
Records,	quires n sign	d by		BESITY					2 🗆 No		/
CO	aw requii s been s 2 should	plete						24a. Was an	24b. W	ere autops	y findings available
		Completed						autopsy performe 1 Yes 2	d2   de	eath?	pletion of cause of
Vital	Physicien: The this certificate har director, page	Be	25. Was case referred to medical examiner?	spital:		0.0	Place of Death (C				
of	두 후 교	. To	1 Yes 2 No	1 Minpatient 2 E	R/Outpatient 3[ 28b. Time of		Nursing Home	5 Residend			
ion	Attending F r death. ector: After by the funera	atlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury M	28c. Injury at Work? 1 ☐ Yes			lary occurre		
Division	after death Director: in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, fa	ctory, office	28f.	Location (Stree City or Town, S	et and Numbe State)	r or Rural F	Route Number,
D	pitel or urs afte arel Dir										
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 ☑ Certifying Physi (Check only 2 ☐ Medical Examine one)	cien: To the best of my knowler: On the basis of examination and manner stated.	ledge, death occu on and/or investiga	rred at the time, dat ation, in my opinion,	te and place, and , death occurred	I due to the caus at the time, date	se(s) and man and place, a	ner as state nd due to th	ed. ne cause(s)
_	To the within To the Comple	Me	29b. Signature and title of certifier			29c. License numb	ber	29d	. Date signed	(Month, Da	y, Year)
)	,		1 M SALV	m PHYSIC	LAN	D052	122	Ji	INE C	03	2005
	10		30. Name and address of person who con	pleted cause of death (Item 2	23a) (Type, Print)	KERNIANI	DPINE	RAITI	MADE		71712
	Sta	te	31. Date filed (Month, Day Year)	DN BOOTH, MD 32. Registrar's Ignatu 7 2005	Ire M	Acasti 2		01/01/1	J IORC	11110	41201
	Registr		JUN (	7 2005 Blow	. الكو ميما	ST. Comment					

		For State Registrar					d / Depa		t of H	ealth and	Mental F	lygie		005	18	946
Physicia /Medic	al	1. Decedent's Name Vivian 4a. Fecility Name (I	Е. Нер	ting	nd number)			4b City	Town or	Location of De	2. Date of Month June	Death 4	Day 4c C	2005	3. Time 9:30	of Death Рм
Examin	er	303 Maid	en Cho	ice Ln.		//	- A 6 :- A6 - 1 - 1	Cato	nsvi					ltimor	e	
Funeral Director		5. Social Security N 218-12-44 Usual Residence of	25	6. Sex 1 □ M 2	X <sub>F</sub> 7. Age	82 	st birthday) Yrs.	Months	Days		8. Date of (Month, 10/24	7192	(ear) 22	9. Bir Ma	thplace (State ountry) ryland	or Foreign
ith the Maryland or 28e-f show	tor	10a. State MD	10b. County Balti				Town or Lo								10d. Inside 0	City Limits
with the 3e or 28e	Funeral Director	10e. Street and Nur		ice Lar	ne			10f. Zip	Code 2122	8		10g	ı. Citize	n of What Co	ountry?	
Ind 21215-0036  be filed within 72 hours after death with the Maryland tal Hygiene. Ital Hygiene. d other than "netural", or ttems 23e or 28e-f show event, the Madical Examither man be notified at	þ	11. Marital Status  1  Never Marri		ried 1 _	s Decedent Ened Forces? Yes & AN es, Give ar or Dates:	Ever in U.S		Was Deced If Yes, spec		spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or erto Rican, etc.)	No-		. Race - Ame Black, Whit pecify: Wh	e, etc.	
Maryland 21215-0036 to 2 shours aft and Mental Hygiene 77 is marked other than "netural", or traumatic event, the Madical Example	Completed	(Special Special ify only highe	nt's Education est grade comp	leted) lege (1-4or 5	+)	(Give life.	dent's Usua kind of wor DO NOT us maker	al Occupa rk done d se retired,	ation furing most of t	vorking			of Business	Industry		
rland 2 uld be filed Aental Hygi rked other	To Be Co	17. Father's Name Charles		Last)							Name (First, Middeth Mach		iden St	umame)		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene 1 Department of Health and Mental Hygiene 1 life may 23e or 28e-f shot any injury or other traumatic event. The Modical Examination was the notified at once.		19a. Informant's Na Deborah  20a. Method of Disp  XBurial 2	Bittri position Cremation 5 Other (S	ck /Dau 3 □Removal	ghter	Ce	28 Si ace of Dispo metery, crea lon Pa	lver sition (Nam natory or or rk 2. Name an	Fox ne of ther place	Court,	Cockey Date 3/2005 itzke Fu E., Balt	svil 200 B	lle, c.Loca alt: al l	MD 2 tion-City or imore,	Town, State MD f Cato	nsvill
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and upper completely filled in by the funeral director, page 2 should be detached for use as the burial-transit of page 2.	Ilcal Examiner	Immediate Cause disease or condition resulting in death)  Sequentially list contains, sading to include Cause (Disease or that initiated events resulting in death) in the cause (Disease or that initiated events resulting in death) in the cause (Disease or that initiated events resulting in death) in the cause (Disease or that initiated events resulting in death) in the cause of t	nditions, modules rhying injury	C	to (or as a		anne oty	nol 3	do	estis					Onset and	Death
P.O. Box 68 that the death certifical ed by the attending phy detached for use as th	by Physiclan/Medl	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? ☐ No	1 4	es, outcome of Live birth Pregnant at Unknown	2 Fetal	death 3[	Ectopic pro				-	230	d. Date of del Month		Year
cords, P.(	ted by Ph	Part II. Other signif	icant conditi	- 1	g to death bu		<i>i</i>	nderlying ca		en in Part I.			cco use		the cause of obably 4	
f Vital Records, insician: The law requires the sertificate has been signed director, page 2 should be continued.	e Completed	per con	ed de	effersi	Du luc	d on	is a	desmo	res	WSAGA	pe 1 □ Yes	topsy normed 2	d2	prior to death?	topsy findings completion of 2 No	available cause of
on of Vij ding Physicie h. After this cert funeral directe	To B	examiner? 1 Yes 2 7  27. Manner of Deat 1 Natural	h 5 □ Pendi	Hospital 28a.	1 ☐ Inpatie Date of Injur (Month, Day	v [	P/Outpatier 28b. Time o Injury		8c. Injury Work	at Nursing	Death (Check only Death (Check	sidenc			cify)	
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could determ	not be	Place of Injubuilding, etc	iry - At hor . (Specify)	ne, farm, str				28f. Location City or	(Stree Fown, S	et and N State)	Vum <i>ber</i> or Au	ıral Route Nur	mber,
To the Hospital or Within 24 hours afte To the Funeral Dir completely filled in	Medical (	29a. Certifier (Check only one)	1 Certifyi 2 Medical	Examiner: On and	To the best of the basis of d manner sta	examination examin	rledge, deat on and/or in	vestigation,	at the tim in my op	oinion, death o	ace, and due to the courred at the time	e, date	and pla	ace, and due	stated. to the cause(	s)
57 wit 70 00 00 00 00 00 00 00 00 00 00 00 00		30. Name and addr	infe	34	d cause of de	Phy Path (Item	SICIA	7	<b>D</b> -	3063	/	290.	61	6/05	., Day, (Edi)	
Sta	te	A C A Cas  31. Date filed (Mon	fer,	singes.	22. Registra	ns	,70	0 6	eipe	Rd,	artonsi	rlle	p	5	212	28
Registr	-	JU	N U 7	2005	Legan	D.	A COS									

			For State Registrer	State o	f Maryland	d / Depa	artment of	f Health a	and Me	ental Hy		005	18947
	Physici	an	1. Decedent's Name (First, Midd	•					2	2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	Carl Edward		- 6 3		11 C' T		15 1	06-	03-	05	8:35a M
	Examir	ier	4a. Facility Name (If not institution		- /			n, or Location of	of Death			Himer	
	Funeral		Franklin Square 5. Social Security Number		7. Age (In yrs. I	ast birthday)	NOSe C	ar If Under	24 Hrs. 8	I. Date of Bir	th	9. Birth	place (State or Foreign
	Director		705-10-2409	1 M 2□F	89	Yrs.	Months Da	ys Hours	Min.	Date of Bir (Month, Da Jan. 1	, 1916	Penn	sylvania
-	· *		Usual Residence of Decedent  10a. State 10b. Count	,	10c City	, Town or Lo	veation						10d. Inside City Limits
200	l sho	ō		timore	100.01.	, 104111 01 20	Balti	imano					1 ☐ Yes 2 ☑ No
9	or 28a-1 show	rect	10e. Street and Number				10f. Zip Cod				10g. Citizer	n of What Cou	ntry?
with the	38 04	io le	4022 Silvage	Road				21	236		и	.S.A.	
1215-0036 Within 70 hours after death with the Maryland	Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic event, the Medical Evaniner must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Mar. 3 Widowed 4 Divorce	ried Armed Fo	2 X No	i	Was Decedent of the Yes, specify 0			fy Yes or No can, etc.)		Race - Americ Black, White, pecify: White	etc.
5-0	natu	etec	15. Deceder (Specify only higher	nt's Education est grade completed)		16a. Dece (Give	dent's Usual Oc kind of work do DO NOT use re	cupation ne during mos	t of working	1	16b. Kind	of Business/In	dustry
121 Jigin	han B Me	Be Completed	Elementary/Secondary (0-12) 12th Grade	College (1	-4or 5+)		DO NOT use re IEEUNG				Regal	k and 1	Joahan
Q 2	Hygie ther i	ပိ	17. Father's Name (First, Middle	Last)		Light	recurry	_		First, Middle	, Maiden Sui		recket
<u>a</u> 2	ked c	To B		miller				Eth		Vautie			
Maryland 21215-0036	alth and N 27 Is mar r traumat		19a. Informant's Name/Relation Mrs. Jeanette		wife)	1	ng Address (Stra						Code)
ore,	of Hei		20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Name of natory or other	place)	Dat	te	20c. Locat	ion - City or To	own, State
_ <u>E</u>	ant: If		1 Burial 2 Cremation 4 Donation 5 Other	Specify) Entomb		rkwood	! Mausol	eum !	6/7/20	005	Baltin	nore, M	laryland
Baltimore,	Depart Import any inj		21. Signature of Funeral Service	Literation			2. Name and Ad 1705 Bel						
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that c	aused the death ach line.	. Do not ent	er the mode of	dying, such as	cardiac or r	respiratory a	rrest,		Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition	a In	tracvar	rial	Hemon	nor h	198				Onset and Death
	/Medical xaminer		resulting in death)	Due to (	or as a consequ	ence of):							-
		e.	Sequentially list conditions,	b. Due to (	ui as a colis <del>o</del> qu	enca off.						-	
De la	ansit	Examiner	ir any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>.</b>									
760,	ohysician and the burial-transit	I Exa	resulting in death) Last	Due to (	or as a consequ	ence of):							
687	physi s the b	dical		d									
Box	igned by the attending pt be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live b	come of pregnar irth 2 Fetal ant at time of de	death 3[	Ectopic pregna Other (specify				23d	. Date of delive Month	ery Day Year
P.O.	ad by detacl	Ph.	Part II. Other significant condit	ons contributing to de	eath but not resu	Iting in the u	nderlying cause	given in Part I		23e. Did t	obacco use	contribute to t	he cause of death?
ds,	signed b	d by	Tanin and algorithms	and sommouting to de	an barnor roos	iling in the a	ildorlying odddo	givoit iit i art i					pably 4 □Unknown
COL	been si	Completed						•		24a. Was	an 2	4b. Were auto	posy findings available
Re de	certificate has rector, page 2	ошо							-	autop	rmed?	death?	opsy findings available impletion of cause of
tal	tificat tor, p	BeC	25. Was case referred to medical	1)				26. Place	of Death (	1 ☐ Yes Check only o		1 🗆 Yes	2□ No
f V	nis cer direc	ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	npatient 2 🗆 E	R/Outpatier	nt 3 DOA	Othor				Other (Specif	(y)
Division of Vital Records, lor Attending Physician: The law requires to	Atter this certificate ha	ii.	27. Mann of Death 1	28a. Date of (Mont	of Injury h, Day Year)	28b. Time o Injury	28c. li	njury at Work?	28	d. Describe I	how injury o	ccurred	
Sio	death. ctor: A y the fu	Certification:		igation and he	-/ Aib-			Yes 2	_	£ 14: ()	C44		10
Oivi S. A.	after of Direction by	ertif		ningd 286. Place	of Injury - At hor ng, etc. (Specify)	me, tarm, sti	eet, factory, offi	Ce	28	City or To	wn, State)	umber or Hura	al Route Number,
	within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifyi	ng Physician: To the	best of my know	vledge, deat	h occurred at the	e time, date an	nd place, and	d due to the	cause(s) and	d manner as s	tated.
H.	24 h le Fur	Medical		Examiner: On the ba and mann	asis of examinati								
± oF	within comp	ž	29b. Signature and title of certific	ər			29c. Lic	ense number	1 ( 1		29d. Date si	igned (Month,	Day, Year)
			Tomo	NDO	<i>ـــ</i>		1	1617	r6 (		06	03/6	) S
1	V		30. Name and address of person	who completed caus	e of death (Item	23a) (Type,			7	1	clfima	Ca 11	171770
	_Ct	10	31. Date filod (Month, Day, Year	Deta Opu	egistrar's Signat	ure ure	IChn Sq	uare	The state of	c 100	(1//10	1) Ma	1 21201
	a Sta Registr				B								
DHMI	H 17 Rev 1/2	001	JU	N 0 7 2005	Blesus	, K	Spent	8					
					(	DRIGIN/							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** June 2,2005 Sarah AKA Sally 2:09pm M Higgins /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 25,1915 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 037-12-5116 1 ☐ M 2 🖼 F 90 Director Vrs Newport, RI Usual Residence of Decedent death with the Maryland 10a State 10h Counts 10c. City, Town or Location r items 23a or 28e-f show 10d. Inside City Limits MD PG Bowie Completed by Funeral Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16203 Penn Manor Lane 20716 TISA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or item Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No traumatic event, it a Mudical Exp. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Real Estate College (1-4or 5+) Broker 12 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wolf Smith Milla Dannin 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marlene H. Mcgehee/Daughter 16203 Penn Manor Lane Bowie, MD 20716 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) ō permit. Page Department of Important: ff any injury or once. Beth Olam Cemetery 6 5105 Middletown RI 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc. R.2 1501 East Fort Ave. Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final **Physician** Preumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy 1 Yes 1 Yes 2 No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner 2 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 V No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 -Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Diractor: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D60058297 12/05

7

State Registrar 31. Date filed (Month, Day, Year)

HOWARD YOUNG MD. Anne Arundelmedical Courter Annapois MD ZIHOI

30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt)

32. Registrar's gnature

MAUREEN HAROLD 05-03805 RKD

		-	For Stata Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of H			iene 005	18949
	Physici	an	1. Decedent's Name (First, Middle, I	.ast)				2. Date of Deat		3. Time of Death
	Physici /Medic	ai .			arold			JUNE	<sup>D</sup> 3, 2005	11:57A. M
	Examin		4a. Facility Name (If not institution, g 226 W. COLDSPRIN	G LANE		BALTIMO			4c. County of Dea	
	Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) C	thplace (State or Foreign
	Director		109-42-0485 Usual Residence of Decedent		56 Yrs.			Mar. 12	, 1949 Ne	w York
	yland now		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Man B-1 st	tor	Maryland		Baltimore	3				1 XYes 2 No
	th the	lrec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
	th wil	a [	226 W. Coldspri	ng Lane		2121	0		USA	
	tems	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S) n, Mexican, Puerti	pecify Yes or No- p Rican, etc.)	14. Race - Am- Black, Whi	
36	J within 72 hours after death with the Maryland jiene. r than natural', or items 23a or 28a-1 show the Mcdical Examinar must be notified at	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 ██N If Yes, Give Year or Dates:		1 X Yes 2□ No	Specify: Cr	anish	Specify:	White
21215-0036	hour fural		15. Decedent's		16a, Deced	ient's Usual Occupa			16b. Kind of Business	
5	n "na	plet	(Specify only highest of Elementary/Secondary (0-12)	grade completed)	(Give	kind of work done o DO NOT use retired	during most of wor.			,
212	d within giene. ir then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	Bool	kkeeper			Construct	ion
b	be filed ital Hygid od other event, il	Bec	17. Father's Name (First, Middle, La	,				ne (First, Middle, I	Maiden Sumame)	
Maryland	s 1 and 2 should be filed f Health and Mental Hyg item 27 is merked otha other traumatic evant,	10	John (nmn)	Harold			Julia	(nm	n) Qui	nones
an	2 sho and is ma		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street a	and Number or Ru	ral Route Number	r, City or Town, State,	Zip Code)
	1 and Health em 27 other tr		Merci Russo - S	ister	124 5	Spruce Wo	ods Cour	t, Abing	don, Maryl	and 21009
ore	00-	1 1	20a. Method of Disposition 1 □ Burial 2 【XCremation 3	☐Removal from State		natory`or other plac			20c. Location - City or	
altimore,	tmen tant:		'4 □ Donation 5 □ Other (Spe		Hilltop S		-		Towson, Ma	
Bal	permit. Page Department i Important: If any injury or once.		21. Signature Funeral Service Lic	Auch		Name and Address 1317 Coke			Funeral Ho gdon, Mary	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplication that caused by one cause on each line	he death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between
	Physician	() I)	Immediate Cause (Final disease or condition	ARTERIOSC	LEROTIC CA	RDIOVASCU	LAR DISE	ASE		Onset and Death
	/Medical Examiner		resulting in death)	u	consequence of):					
H.	Examine	L	Sequentially list conditions,	b						
V	be sit	-lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
	and Il-transit	Examlne	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
8760	death certificate be executed to attending physician and of for use as the burial-transit			d						
687	ficate phys	edical		d						
Вох	eath certific attending pl	Z/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		7C-ti			23d. Date of de	livery
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 4 Pregnant at 1		]Ectopic pregnancy ] Other <i>(specify)</i>			Month	Day Year
P.0	at the de by the tached	Physician/M	9 🗆 Unknown	9□ Unknown					_	
	as the	by F	Part II. Other significant conditions	s contributing to death bu	t not resulting in the u	nderlying cause give	en in Part I.		bacco use contribute t	
Records,	w require been si should b							1 🗆 Ye	es 2□No 3□P	robably 4 Unknown
မင	e taw r has be	ple						24a. Was a autops	sy prior to	utopsy findings available completion of cause of
<u> </u>		Completed						perform 1 ☐ Yes		s 2□ No
Vital	Physician: this certific ral director,	Be	25. Was case reterred to medical examiner?	Heavitali		Oth		th (Check only on		CCENE
of	Physi this c	2	1 XYes 2 No	Hospital:			4   Nursing n		ence 6 AOther (Spe	ocify) SCENE
	ling After une	lon	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 280. Time of Injury	Worl	yat k? Yes 2 □ No	280. Describe no	ow injury occurred	
isi	tand Jeatl tor: the	icat	2 Accident investigat 3 Suicide 6 Could no	t be ago Place of Inju	ry - At home, farm, str		163 2 110	28f. Location (St	treet and Number or R	ural Route Number.
Division	or Attand after death Director:	Certification;	4 Homicide determin	building, etc	(Specify)	oon (actory, cines		City or Town		
_	To tha Hospital or At within 24 hours after or To tha Funaral Direct completely filled in by			Physician: To the best o						
	n 24 f na Fui	edical	(Check only 2 X Medical Ex	aminar: On the basis of and manner sta		vestigation, in my o	pinion, death occu	rred at the time, d	late and place, and du	e to the cause(s)
	To the Ho within 24 I To the Fu completel	Me	29b. Signature and title of certifier	, .		29c. License OCM		2	9d. Date signed (Mon	th, Day, Year)
			> his	w.m.	>				JUNE 3, 20	005
	Ø		30. Name and address of person wi	no completed cause of de	ath (Item 23a) (Type,	Print 11 Pen	n Street	Baltim	ore. Marvl	and 21201
			LING LI MD.							
	Sta		31. Date filed (Month, Day, Year)	2005 32. Registra	r's Signature	haster				
	Regist	ar	JUN 0 7	LUUS PROPERTY	w N M	-				

			For State Registrar	State of N	Maryland		irtment of I	Health and I Death	Mental Hy	gierie	05	18950
			Decedent's Name (First, Middle, Last	)					2. Date of De	eath		3. Time of Death
_	Physici		Gerard Joseph	n Hessl	e <b>r</b>				June	4, 2005	Year	4:30P <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Town,	or Location of Death			nty of Death	
			Gilchrist Hosp	oice			Towso	n		Ва	1timo	re
	Funeral		Social Security Number     6. Se		Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	B. Date of Bir (Month, Da	rth ay, Year)	9. Birth	place (State or Foreign ntry)
	Director		213-30-0892	M 2□F	72	Yrs.			Jan. 14	1933	Ma	aryland
	and *		Usual Residence of Decedent  10a. State 10b. County	<del></del>	10c. City.	Town or Loc	cation					10d. Inside City Limits
00	faryli sho	5	MD Balti	m <b>o</b> ***		Cimoni						1 ☐ Yes 2X No
W.	the A	Director	10e. Street and Number	Inore		LIMOILI	10f. Zip Code			10g. Citizen	of What Cou	ntry?
1	with Be or		21 Tintern Ct. # 2	01			2109	2				,
٧.	Jeath ns 23	Funerai	11. Marital Status	12. Was Decede	nt Ever in U.S	. 13. V	Vas Decedent of	Hispanic Origin? (S	pecify Yes or No	D- 14. F	SA Race - Ameri	
05	or iter		1 ☐ Never Married 2 ☐ Married	Armed Force 1 [X]Yes 2 [ If Yes, Give				an, Mexican, Puert	o Rican, etc.)		Black, White,	
7	1215-0036 within 72 hours after death with the Maryland ene.  9ne. han "natural", or items 23e or 28e-f show he death of the most of the modified at the modif	by	3 Widowed 4 Divorced	Year or Date	s:	'	☐ Yes 2M No	Specify:		Spe	city: W]	nite
14019	5-C	Completed	15. Decedent's Edu (Specify only highest grad	cation e com <i>pleted)</i>		(Give I	ent's Usual Occu kind of work done	during most of wor	rking	16b. Kind o	f Business/Ir	ndustry
0	2121 id within giene.	mpi	Elementary/Secondary (0-12)	College (1-40	or 5+)		OO NOT use retire	•				
	12 lied v Hygie ther t		17. Father's Name (First, Middle, Last)	N/A		Se	rvice Ma	nager 18. Mother's Nar	ne /First Middle		puter	
Gerard	Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importantis if time 721s marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Be	Frank G. Hessler						dine Fr			
S. B.	should Me mark	10	19a. Informant's Name/Relationship (T)	rpe, Print)		19b. Mailin	g Address (Stree	and Number or Ru			wn, State, Zij	Code)
20	Ma d 2 s lith ar 27 ls r trau		Cecilia L. Volkmar		r			ce Road I		1962 6.00-0		
9	re, s 1 ar f Hea item othe		20a. Method of Disposition		20b. Pla	ice of Dispos	sition (Name of		Date		on - City or T	own, State
2	Pager ent of nt: If i		1 X Burial 2 ☐ Cremation 3 ☐ P  '4 ☐ Donation 5 ☐ Other (Specify)		te Dul	aney	valley Cardens	200		Tim	onium.	MD
Sle	Baltimore, permit. Pages 1 ar Department of Hea mportant: If item any injury or other once.		21. Signature of Fun and Salvice Dicer	00	Меш	22.	Name and Addr	eral Home				
Yessler,	Bal permit Depar Impo any ir		Kitch	ael J. i	lagle	10	W. Pado	erar nome nia Road	Timoniu	m, MD	arrey, 21093	inc.
He			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caus	sed the death.	Do not ente	er the mode of dy	ng, such as cardiad	or respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	End	. 1	tge	abstra	rctive	Lunge	Liseas	e	Onset and Death
	/Medical		resulting in death)	d	as a conseque				J			5
	Examiner		Sequentially list conditions,	b								
	sit ad	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseque	ance of).						
	ecute and I-tran	хаш	that initiated events resulting in death) Last	c. Due to (or	as a conseque	ance of):					_	
	58760, irate be executed physician and s the burlal-transit			222.00 (3.								
	physicate s the	dical		d								
	certifi certifi	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor						23d.	Date of deliv	erv
	Box	Physician/Me	in the past 12 months?	4☐Pregnan	2 ☐ Fetal of t at time of dea		Ectopic pregnand Other (specify) _	:у		.11	Month	Day Year
	P.O. nat the d by the detached	hys	9 Unknown	9□ Unknowr	1							
		by P	Part II. Other significant conditions co	ntributing to deat	h but not resul	ting in the ur	nderlying cause g	ven in Part I.	23e. Did	tobacco use c	ontribute to t	he cause of death?
	cords w require been sig								Ť.	Yes 2□No	3 ☐ Pro	bably 4 Dunknown
	eco taw re as bee	piet							24a. Was	s an 24	b. Were auto	opsy findings available
	Vital Re(sician: The lavecertificate has rector, page 2	Completed							perf	ormed? 2 X No	death?	ompletion of cause of 2□ No
	ital	Be C	25. Was case referred to medical examiner?					26. Place of Dea				
	of Vita Physician: this certifica	10	1 ☐ Yes 2 🗷 No	Hospital: 1 ☐ Inpa	atient 2□E	R/Outpatien	1 3 DOA	and the second s	lome 5 Res	idence 6 🔽	Other (Speci	m) Hospice
	On O ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	28c, Inju		28d. Describe	how injury oc	curred	
	SiO tendi eath. for: A	cati	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 No	201 1 11	(0)		
	Division of Vital Records, to Attending Physician: The taw requires the after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be contact.	Certification:	4 Homicide determined	28e. Place of building,	Injury - At hon etc. (Specify)	ne, farm, stre	eet, factory, office			(Street and Nu wn, State)	mber or Hur	al Route Number,
	pital purs a ours a eral [		29a. Certifier 1 Certifying Phy	eician: To the he	est of my know	riedge death	occurred at the t	ime date and place	and due to the	cause(s) and	manner as s	tated
	Division of Vital Rewithing Physician: The within 24 hours after death. To the Funeral Director: After this certificate in completely filled in by the funeral director, page	Medical	(Check only 2 Medicel Exam		s of examination							
	Fo the within Fo the	Me	29b. Signature and title of certifier	Λ	D		29c. Licen	se number		29d. Date sig		
			19/ Huth	my the	Ky.	no	DZ	5700		June	25,0	2005
	104		30. Name and address of person who c	mpleted cause	of death (Item :	23а) (Туре,	Print)	2. (i D	- Phi	no 1 -	, 3 -1	(
	2							201.10	Cirio.	ria C	(20)	~
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 200	32. Reg	istrar's Signatu	Jre Gasa						

State of Maryland / Department of Health and Mental Hygiene 15 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Пач Year **Physician** Hudson Ernest 12:15 P M 2005 June 1. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town or Location of Death Examiner NA Baltimore 3110 Presbury Street If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11-30-1947 5. Social Security Number 9. Birthplace (State or Foreign Funeral 1**X**M 2□F Months Days Hours Min Yrs Maryland Director 216-52-9857 57 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County Item 27 is marked other than "naturel", or items 23s or 28s-1 show other traumatic event, the Mcdical Examinar must be notified at 1 Yes 2 □ No Director NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21216 3110 Presbury Street death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel', or Item any Injury or other traumatic event, the Middical Examinations. Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Super Market Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Irene Cunningham James A. Hudson ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3110 Presbury St. Baltimore, MD 21216 Rhoda V. Hudson/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBuriai 2 Cremation 3 Removal from State Sacred Heart Cemetery 06-08-05 Baltimore, MD \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor St. Balto, MD 21217 ones 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DIVa /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit Due to (or as a consequence of) ettending physician Box 68760 Physician/Medical use as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 4□Pregnant at time of death P.0. the 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1/1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physiclen: within 24 hours after death.

To the Funerel Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 X No 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: Natural 2 Accident investigation 1 Yes 2 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 003 471 de un ompleted cause of death (Item 23a) (Type, Print) 30. Name and address of person 5 Greene evin 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar JUN 0 7

Glenn Hawkins 05-3678 AKG

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	1. Decedent's Name (First, Middle,	Last)				2. Date of Death Month	Day V	3. Time of Death
cian Iical	Glen Williams Haw	$\epsilon$ ins G $1$ enn L $\epsilon$	muel Will	iams		May 28	, <sup>Day</sup> 2005	12:34 P
iner	4a. Facility Name (If not institution,	give street and number)			Location of Death	-	4c. County of	
	Northwest Region	al Hospital		Randall				ore County
l r	214-92-5978	5. Sex 7. Age 7	(In yrs. last birthday) 46 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 04-15-1959	(ear) 9. (Ma	. Birthplace (State or Fore Country) aryland
	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Lim
ŏ	MD	NA.		Baltimore				1 <b>XX</b> Yes 2 □
Director	10e. Street and Number			10f. Zip Code		100	J. Citizen of Wha	at Country?
al D	2705 Ruscomb Lane			2121	5		USA	
Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.1	Was Decedent of H	ispanic Origin? (Spe in, Mexican, Puerto	ecity Yes or No- Rican, etc.)		American Indian, White, etc.
	1 Never Married 2 Marrie	d 1 ☐ Yes 2/2/2/No If Yes, Give	)	1 ☐ Yes 2 🛣 No	Specify:	. ,	1	•
d by	3 Widowed 4 Divorced	Year or Dates:	16a Daga	dent's Usual Occup	ntina	10	Specify: E	
Completed	15. Decedent's (Specify only highest	grade completed)	(Give	kind of work done of DO NOT use retired	during most of worki	ng	ib, Kind of Busin	less/industry
E G	Elementary/Secondary (0-12)	College (1-4or 5+	) [	ndy Man	,		Home Impr	ovenent.
Be	17. Father's Name (First, Middle, La	ast)			18. Mother's Name	(First, Middle, Ma	iden Sumame)	
To B	James C. Hawkins	3			Gwenever	e Williams		
-	19a. Informant's Name/Relationshi	p (Type, Print)	19b. Mailir	ng Address (Street	and Number or Rura	l Route Number, C	City or Town, Sta	ite, Zip Code)
	Renard Hawkins/ Brot	her			venue Baltin		215	
	20a. Method of Disposition 1 Darial 2 Cremation 3	3 Removal from State		matory`or other plac	(e)	ate 20	c. Location - Cit	y or Town, State
	'4 □ Donation 5 □ Other (Spe		Metro Crema	atory	06-06-	-05 C	atonsvill	e, MD
i king	21. Signature of Funeral Service Li	censee	22	2. Name and Addres	ss of Facility			
K	Jumera	, yours						imore, MD 2121
	23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caused to nly one cause on each line	ne death. Do not ent	ter the mode of dyin	g, such as cardiac o	r respiratory arres		Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	a_ Cardiac	Arrhythm	ia				3.03, 2.00
	i dodaini g iii dodaini,	Due to (or as a	consequence of):					
i i	Sequentially list conditions,	b. — Due to (or as a	consequence of):					
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cause or injury that initiated events							
×a	resulting in death) Last	Due to (or as a	consequence of):					
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edical	IS SEMALS.	0.						
edical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		Ectopic pregnancy			23d. Date of	
edical	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date o Month	f delivery Day Year
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DHMH 17 Rev 1/2001

ORIGINAL

			1- State of Maryland / Department of Certificate of		lental Hygie	4000	18954
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Clara M. Healy		2. Date of Death Month June 2,	2005 Year	3. Time of Death 6:14 P.M
	Examin			m, or Location of Death timore City	,	4c. County of Death	
	Funeral Director		212-58-3400 10 m 2x 98 yrs.	ear If Under 24 Hrs. ays Hours Min.	8. Date of Birth (Month, Day, Ye March 30	9. Birthp Cour 1,1907 Ma	place (State or Foreign ntry) ryland
	land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			1	0d. Inside City Limits
	a-f sh	tor	Maryland N/A Baltimore Cit	.y			1 XYes 2 □ No
	or 28	Director	10e. Street and Number 10f. Zip Cod		10g.	Citizen of What Cour	ntry?
	eath v		910 Eastern Avenue 212  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent		ocify Ves or No-	U.S.A.	ean Indian
920	be filed within 72 hours after death with the Maryland stal Hyglene. ed other than "natural", or Items 23a or 28a-f show event, the Marical Evair It wit must be indiffed at	by Funeral	Armed Forces?  1 Never Married 2 Married I Yes 2 No If Yes, Siew Year or Dates:  Armed Forces?  1 Yes, Siew 1 Yes, Siew 1 Yes 2 No If Yes, Siew Year or Dates:	of Hispanic Origin? (Spe Cuban, Mexican, Puerto I No <i>Specify:</i>	Rican, etc.)	Black, White,	
2-0	72 ho	eted	15. Decedent's Education 16a. Decedent's Usual Or (Specify only highest grade completed) (Give kind of work di	one during most of working	ing 16t	. Kind of Business/In	dustry
121	filed within Hygiene. other than '	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker	tirəd)		Own Home	
Maryland 21215-0036	be de la la la la la la la la la la la la la	To Be C	17. Father's Name (First, Middle, Last) Henry F. Cuneo	18. Mother's Name Fran	(First, Middle, Mail		no
Mary	12 7 Isa		19a. Informant's Name/Relationship ( <i>Type, Print</i> ) Andrew F. Healy - Son  19b. Mailing Address ( <i>Str.</i> 3841 Brave	reet and Number or Rura heart Drive			Code) 1704
Baltimore,	Pages 1 and nent of Healt int: If item 2 iry or other		20a. Method of Disposition  1 🔀 Burial 2 □ Cremation 3 □ Removal from State  1 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name of Cempetery, Crematory or other Holly Redeemer	r place) Cem. 6-6-0		Location - City or To Baltimore,	
Balti	permit. Pages 1 Department of H Important: If ite any injury or ot once.		Leonard	J. Ruck, In	ic. 5305	Maryland Harford R	
			23a. Part1. Enter the disease, or complications that caused his death. Do not enter the mode of shock, or heart failure. List only one cause on each line.	dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  ANTENIDS CLEROSIS (  anti-property of the condition of the c				Onser and Death
	Examiner		Due to (or as a consequence of):	GTRIAL	. FIBR	LLATION	/
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7	ate be executed hysician and the burial-transit	Examine	Cause (Disease or righry that initiated events resulting in death) Last c. Due to (or as a consequence of):	16/1761	1 / 1 / 2	476	
8760,	e be e /sician e buris	dicai E	d				
9	ntificate ng phys s as the	Medi	IF FEMALE:				
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Vital Record	The law ate has b page 2 s	Comple			24a. Was an autopsy performed	? prior to cor death?	psy findings available mpletion of cause of 2 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death Other:			
of		n: To	27 Manny of Death 28a. Date of Injury 28b. Time of 28c.	4   Nuising Hon	ne 5 🗌 Residence 28d. Describe how i	e 6 □Other (Specify njury occurred	/)
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Division	safter death safter death al Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury · At home, farm, street, factory, off building, etc. (Specify)	ice 2	28f. Location (Stree City or Town, S	t and Number or Rura tate)	l Route Number,
	To the Hospital or a within 24 hours after To the Funeral Dire completely filled in b	edical (	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the control of the basis of examination and/or investigation, in rand manner stated.	e time, date and place, a ny opinion, death occurre	and due to the cause ed at the time, date	e(s) and manner as si and place, and due to	ated. the cause(s)
	To the To the Comp	×	29b. Signature and file of certifier Listell.	cense number 18	3 29d.	Date signed (Month)	Day, Year)
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALKER IM PAGUATECLI (2) SU	YATH EAT	OIU St.	BACT, W	(1)21224
	Sta Registr		31. Date filed (Month, Day, Year)  JUN 9 7 2005  Make M. Goods			/	

			For State Registrar	State of Maryland	-	artment o			nd Mental F	lygiene Reg. No	UUD	18955
	Physici	an	Decedent's Name (First, Middle, Last)						2. Date of Month	Da	y Year	3. Time of Death
	/Medic	al	Alberta	E. Hoover					June		05	5:55 A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give st			4b. City, To			Death		County of Death	
	Eupovol		Glen Meadows Retire 5. Social Security Number 6. Sex	7. Age (In yrs. lasi		If Under 1		f Under 2	4 Hrs. 8. Date of	Birth	Baltimore 9. Birth	
	Funeral Director		214-50-7438	<sup>1 2□</sup> X <sup>‡</sup> 98	Yrs.	Months E	Days I	Hours	Min. (Month, Sept.	Day, Year)	.906 P	place (State or Foreign Intry)
	p a		Usual Residence of Decedent  10a. State 10b. County	10c. City, 7	oum or La	antina						
	fanyla sho	ō										10d. Inside City Limits 1 ☐ Yes 2 X No
	the A	Director	Maryland Baltimore  10e. Street and Number	<u> </u>	en Ar	10f. Zip Co	ode			10a. Cit	izen of What Cou	
	3a or	i Di	11630 Glen Arm Roa	1			1057				U.S.A.	,.
	death	Funerai		Was Decedent Ever in U.S.	13.			anic Origi	in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ameri	
36	or Ita		1 Never Married 2 Married	Armed Forces?  1 Yes 2 No If Yes, Give	1	1 □ Yes 2 🖸		Specify:	r dente rincari, etc.)		Black, White,	etc.
Ö	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show deal Examber and be matter	ed by	3	Year or Dates:		dent's Usual C	`			105 10	Whi	
5	in 72 n "na	Completed	(Specify only highest grade	completed)	(Give	kind of work of DO NOT use	done dun	ing most	of working	160. K	ind of Business/Ir	dustry
212	d with giene er tha	mo;	Elementary/Secondary (0-12)	College (1-4or 5+)	Но	omemake	er				)wn Home	
힏	al Hy d othe	Be C	17. Father's Name (First, Middle, Last)				18	3. Mother	's Name (First, Mid			
yla	ould by Ment arked arked	T <sub>O</sub>		Hendricks				Sar		zabet		Beth
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic avant, the Madical Examble or unit by mailled at once.		19a. Informant's Name/Relationship (Type						or Rural Route Nui			
	1 and Healt am 2		Betty H. Mac Dona 20a. Method of Disposition	20b. Place	e of Dispo	entree	of	ve	Phoenix,	_	and 211	
nor	ages int of t: If It y or o		1 ☐ Burial 2 【XCremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	noval from State cem	etery, crer	natory or othe	er place)					
Baltimore,	nit. Partme ortan injur		21. Signature of timeral Service Licensee		-	Name and			5-7-2005			laryland Home, Inc.
ä	Dermi Depa Impo any ii		Hay to daga	-	1	1050 Yo	ork R	Road	Towson,			204
	/Medical Examiner be be executed by sician and burial-transit sthe burial-transit	Examiner	23a. Part1. Enter the disease, or complicion shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	ce of):		A ( .	3 he	im ly	, arrest,		Approximate Interval Between Onset and Death
.O. Box 68760,	death certif e attending d for use a	Physician/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ▷ No 9 □ Unknown	. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	ath 3	Ectopic pregi				-	23d. Date of delive Month	ary Day Year
Vital Records, P	The law requires that the ste has been signed by the bage 2 should be detached.	by	Part II. Other significant conditions control	buting to death but not resultin	ng jarthe ur	$\sim$	given i	in Part I.		d tobacco u		he cause of death?
900	aw re	Completed	Hypert	en suon					24a. W		24b. Were auto	psy findings available
Ä		Com								topsy rformed? 2 2 No	death?	mpletion of cause of 2□ No
/ita	icien: Th certificate ector, pag	Be C	25. Was case referred to medical examiner?					6. Place o	of Death (Check on	/		
of \	Physicien: r this certifica ral director, p	<sup>L</sup>	1 Yes 2 No		/Outpatien			7	sing Home 5 Re			(v)
LO	ding Ph h. After th funeral	tion	1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	b. Time of Injury	∠8C.	Injury at Work? 1 □ Yes	2 🗍 N	28d. Describ	e now injur	y occurred	
Division of	Attan deat ctor: y the	Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home	, farm, str			, 20,,,	28f. Location	(Street an	d Number or Rura	al Route Number,
á	s after	Serti	4  Homicide determined	building, etc. (Specify)					City or	Town, State	)	
	To the Hospital or Attanding Physicien: within 24 hours after death.  To tha Funaral Diractor: After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only one)  Certifying Physic Z Medical Examine	ian: To the best of my knowle r: On the basis of examination and manner stated.	dge, death and/or inv	occurred at t vestigation, in	the time, o	date and on, death	place, and due to to occurred at the time	ne cause(s) e, date and	and manner as s place, and due to	tated. the cause(s)
	To the within 2 To tha complet	ž	29b. Signature and title oncertifier	( )			icense nu		,		te signed (Month,	
			Kom	ana Yopalon	MD		512	28		6	16/2	205
	6		30 Name and address of person who com	pleted cause of death (lem 23	Type.	Print)	ોજડડ	ROP	AS #159	BACI	MORE	005 M) 21228
	Sta Registr	100	31. Date filed (Month, Day, Year)  JUN 0 7 20	32. Rigistrar's Signature	•							

			Plea amend ite 1- State Registrar	se Type or Pri m#2 perDVR State of M		delible Ink. artment of F			from Not 1	ible. ) 5	18956
	Physici /Medi	an	Registrar     Decedent's Name (First, Middle)	, Last) MORRIS			JR.	2. Date of De Month June 3	Day	Year 2005	3. Time of Death
미	Examir		4a. Facility Name (If not institution Greater Baltim			Towso			4c. Count Ba1	y of Death .timor	e
	Funeral Director		5. Social Security Number 132-03-1833 Usual Residence of Decedent	6. Sex 7. A	ge (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 06-25-	1918	9. Birthpi Coun MAI	lace (State or Foreign try) RYLAND
•	Maryland a-f show	tor	10a. State 10b. County MD. BALT	MORE	10c. City, Town or Lo	ocation TIMO	NIUM			10	0d. Inside City Limits 1 ☐ Yes XX No
	th with the 23a or 28s	al Direc	10e. Street and Number 12101 TULLAMO	ORE COURT,	#201	10f. Zip Code	1093		10g. Citizen of	What Coun	•
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 is markad othar than "natural", or Itams 23s or 28s-f show other traumatic event, the Medical Examinating that be mailthed at	Completed by Funeral Director	11. Marital Status  1 □ Never Married	12. Was Decedent Armed Forces' ed Y∑Yes 2☐ If Yes, Give Year or Dates:	No MALL TT	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 🏋 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Speci	ce - Americ ick, White, e	
Maryland 21215-0036	ithin 72 hou Je. nan "natura Medical E	npleted	15. Decedeni (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed)  College (1-4or	16a. Dece		during most of work d)	king	16b. Kind of E		lustry
and 21	t be filed w ntal Hygier ad othar th	Be	17. Father's Name (First, Middle, MORR)	,	DRICKSON,	ARCHITEC SR.	18. Mother's Nam		, Maiden Suma		
Maryl	nd 2 should th and Me 27 Is mark r traumatio	T <sub>O</sub>	19a. Informant's Name/Relationsi SARAH J. KOUSOU	nip (Type, Print)	19b. Maili	ng Address (Street	and Number or Rui	ral Route Numb	er, City or Town	, State, Zip	Code)
Baltimore,	permit. Pages 1 and 2 Department of Health ar Important: If itam 27 Is any injury or othar trau		20a. Method of Disposition  1 ☐ Burial ※ Cremation  4 ☐ Donation 5 ☐ Other (S)		20b. Place of Dispo	sition (Name of	>	Date	20c. Location	- City or To	
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service		2:	2. Name and Addre			TNC 10	50 YOF	RK ROAD MD.21204
	Physician /Medical Examiner  nuial-transit	Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	d the death. Do not entine.  Shive H  a consequence of):  a consequence of):	•	-		rrest,		Approximate Interval Between Onset and Death 2 days
Division of Vital Records, P.O. Box 68760,	eath certificate b attending physic for use as the b	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	of pregnancy	∃Ectopic pregnancy ∃ Other (specify) _	/			ate of deliver	ry Day Year
ds, P.	w requires that the deben signed by the should be detached	þ	Part II. Other significant condition	ns contributing to death I	out not resulting in the u	nderlying cause giv	en in Part I.		obacco use con Yes 2 □ No		e cause of death?
II Recor	The law req	Completed						24a. Was autor perfo	osy ormed?	prior to con death?	psy findings available appletion of cause of 2 No
ion of Vita	nding Physician: The lavath. ath. r: After this certificate has te funeral director, page 2	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pendin investig			f 28c. Injur Wor	4 LINUISING HO	ome 5 ☐ Resid			)
Divis	To the Hospital or Attending Is within 24 hours after death.  To the Funeral Director: Atter completely filled in by the funer.	Certification:	3 Suicide 6 Could r 4 Homicide determ	ned 28e. Place of in building, e	jury - At home, farm, str tc. (Specify)			City or Tov			
	the Hosp hin 24 hou tha Funar npletely fil	Medical	29a. Certifier (Check only one)  29b. Signature and Attle of certifier	g Physicien: To the best examiner: On the basis of and manner st	of examination and/or in	h occurred at the tir vestigation, in my o	pinion, death occur	red at the time,	date and place,	and due to	the cause(s)
	T wil		> /lather	mE		D006	0632		June 3		*
E	Sta	to.	30. Name and address of person  BEN HERMAN  31. Date filod (Month, Day, Year)	6701 N. CH	ARLES ST	BALTIN	nore m	0 2120	04		
	Registi	. 5 13	JUN 0 7	2005	rar's Signature	wei)					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item#19b3perFH 684/4.6/7/05 CC Partment of Health and Mental Hygiene 15 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Linda Maria Imes 30 2005 734 /Medical May 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner St. Agnes Healthcare Baltimore N/AIf Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 220-74-6668 1 □ M 2√2 F Yrs. Director July 21, 1957 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral, or items 23s or 28s-f show Exertires round be notified at N/AMaryland Baltimore Y⊟Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3714 Mohawk Avenue 21207 USA Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If them 27 is merked other the any injury or other trainer. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Income Maintenance Specia|State of Maryland Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Betts Arlene Imes 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21223 Nathaniel Imes/ Son 428 S. Bentalow St. Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Cemetery | 6/6/05 Baltimore, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, erock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Seo Shock 3 days disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 A No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) Certification: To 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18203 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tuenne Caton HIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 7 2005

Registrar

JUN 0

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11 15

			For State Registrar	State of Ma	arylan	•	artmen rtificate			wentari		i No.	J	18958
	Physici	an	Decedent's Name (First, Middle, Last     Evelyn E.		n					2. Date o		Dey 20	Year 05	3. Time of Death 4:30 P M
	/Medic Examin		4a. Facility Name (If not institution, give				4b. Civ.	Town, or L	ocation of Deatl	June	=	4c. County	05 of Death	4.30 2
H	Examin	eı.	Future Care Cherr						Mills					imore
	Funeral		5. Social Security Number 6. Se	x 7. Age	e (In yrs.	last birthday)	If Under Months	0	If Under 24 Hrs. Hours Min.	8. Date of	Birth , Day, Y			place (State or Foreign
	Director		215-03-6495	]M 2.XF		86 <sup>Yrs.</sup>	WIGHTIS	Days	riodis iviiri.				Mary	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						1	0d. Inside City Limits
	Maryl f sho	ro	Maryland Baltimo	ro				+	L					1 ☐ Yes 2 🔯 No
	r 28e	Director	10e. Street and Number	T.G			10f. Zip	terst	LOWII		100	. Citizen of W	hat Cour	ntry?
	h with	ai D	6 Carlton Crest (	Court				211	L36			US	A	
	ems :	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U	.S. 13. \	Was Deced	dent of Hisp	panic Origin? (S Mexican, Puert	pecify Yes or	r No-	14. Race		an Indian,
39	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "netural", or items 23a or 28e-f show event. The Madical Examination at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2X N If Yes, Give Year or Dates:	lo		1□Yes 2				,	Specify:		ite
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2	ithin 7	npie	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5	+)					rking				
	filed wi Hygien ther the	Cor	12			Me Me	dical		etary				spita	al
Maryland	9 7 5	Be	17. Father's Name (First, Middle, Last) Henry Johnson					1	8. Mother's Nar	me <i>(First, Mic</i> sie Per			e)	
Ë	should be nd Menta marked imatic ev	은	19a. Informant's Name/Relationship (T	one Print)		19h Mailin	ng Address	(Street an	d Number or Ru				State Zin	Cadal
<u> </u>	ith an 27 is r trau		Christina Logan/n			1								
ē,	es 1 and 2 should b of Health and Ment fitem 27 is marked r other traumatic e		20a. Method of Disposition		20b. P	Place of Dispo	sition (Nam	ne of	st Cour	Date	20	c. Location -	ity or To	wn, State
Ë	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)						nc 6/7	7/05		Balti	nore	. MD
Baltimore,	permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Seven Days	e Omus		Ç	remat	d Address	of Facility Ociety ck Road	of Mar	ylaı			
		-	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	onald ications that caused	the deat								2122	Approximate
	Physician		Immediate Cause (Final											Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Chronia Due to (or as a	a conseq	uence of):	Choe	- rui	Monar	7 101	75.61	3.5		
	Examiner		On and the Parameters	b	,									
	p =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a conseq	uence of):								
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a										
ec,	rificate be executed to physician and as the burial-transit	al E		Due to (or as a	a conseq	derice dr).								
9/89	ifficate g phys as the	edical		d										
XOA		-	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			De					23d. Date	of delive	iry
	death	Physician/A	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pre Other (spe				_	Mon		Day Year
J.	at the de by the a stached	hys	9 Unknown	9□ Unknown										
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0	w require been sig should b	eted	Atrial Fibrilla	L						1	Yes	2 🗆 NO	3 [] Prob	ably 4 □Unknown
Hecords,	e law has b	Completed	Hypertension	Anemia	120	enal:	Insu	416	iency		Vas an utopsy erforme	pi	ere autorior to con eath?	osy findings available apletion of cause of
ä										1□ Ye	s 2 🖸		Yes	2 No
Vital	Physician: this certific al director,	o Be	25. Was case referred to medical examiner?	Hospital:	- 20	ER/Outpatien			26. Place of Dea			0 000		
0		-	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injur	y	28b. Time of		8c. Injury a	4 <b>∑</b> Nursing H	28d. Descri	be how	injury occurre	r ( <i>Specit</i> y id	")
0	tr A P di	atio	1 Natural 5 ☐ Pending investigation	(Month, Day	rear)	Injury	М	Work? 1 ☐ Ye	s 2 🗆 No					
DIVISION	_ 0	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc	iry - At ho (Specify	ome, farm, stre	eet, factory,	office			n (Stree Town, S		r or Rura	l Route Number,
	pital burs a leral (		29a. Certifier 17 Certifying Phy	sicien: To the best of	of my kno	wledge death	occurred a	at the time	date and place	and due to	the equi	20/0) and man		atad
	To the Hospital o within 24 hours aff To the Funeral Di	edical		ner: On the basis of and manner sta	examina	tion and/or inv	estigation,	in my opin	nion, death occu	rred at the tir	ne, date	and place, a	nd due to	the cause(s)
	within To th compl	Me	29b. Signature and title of certifier				29c.	. License r	number		29d.	. Date signed	(Month, I	Day, Year)
1	4		> Karen & E	alte, 1	1, D.			Doos	18676		30	ane c	, 20	05
ì	2		30. Name and address of person who co	ompleted cause of de	eath (Item	1 23a) (Type,	Print)					- > -		2 . 2 /
-	,		Caren L. Babit 31. Date filed (Month, Day, Year)	1 MIP. 2	-5 A	rain S	weet	34 j	te 200	1415	ter	5 KW	M	P (113)
	Sta Registr	te	31. Date filed (Month, Day, Tear)	7 2005 Pegistre	es signa	IUI O	Dogs	and I						

			1 – For State Registrar	State of M	aryland / Dep <i>Ce</i>	ertificate of			jiene () ()	5	18959
			1. Decedent's Name (First, Middle, Last	)				2. Date of Deat	th	Vana	3. Time of Death
	Physic /Medi		Mary	El	izabeth	Jo	ohnson	Month Lau	29 20	Year US	5:05AM
Holmson	Examin		4a. Facility Name (If not institution, give 5. Social Security Number 6. Se	2 0 3 3 7. AS	Of "Mure go (In yrs. last birthday	Back If Under 1 Year		8. Date of Birth	4c. County	9. Birthol	ace (State or Foreign
3	Director		248-32-5703	]M 2 <b>X</b> ]F	79 Yrs.	Months Days	Hours Min.	O7 I	9 <sup>rear)</sup> 25	Coun	ŠC
5	pu *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	anation				44	d. Inside City Limits
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3	with t	Ö				10f. Zip Code		1	0g. Citizen of W		ry?
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	ज़ 📆 🚆	Funeral	1 Never Married 2 Married	Armed Forces?		If Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black	, White, e	
	036 Jrs at	by	X☐XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	B	lack
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<	d 212 filed withi Hygiene. ther than	NO.	12th grade	3yrs		laim Exa	aminer		Social	Sec	urity Adm
8	be file tid oth	Be (	17. Father's Name (First, Middle, Last)	•			18. Mother's Name				•
2		10	Elwood Moore	220-01			Maggie	Dewitt	t		
7	- C1 (0 - M	0.	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mai	ling Address (Street	and Number or Rura	al Route Number	r, City or Town, S	State, Zip	Code)
-			Barry Johnson-S	on			lk Ave,				1215
P	More, Pages 1 and of Heal of H		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ F	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of amatory or other pla	ice)	Date	20c. Location - (	City or To	wn, State
	Faginers Fagins		`4 ☐Donation 5 ☐ Other (Specify)			n Forest	t Vet. 6	/9/05 0	Owings	Mil	ls, Md
	Baltimore, permit. Pages 1 ar Department of Hea Important: If item: any injury or other		21. Signature of Funeral Service Licens	"X el	ع ا	22. Name and Addre Masch 4355 Wat	H West Dash Ave	, Balti	imore,	Md	21215
	PERMIT		23a. Part . Enter the disease, or composhoul, or heart dure. List only o	ications that bause							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cand	DOONTS	Doork	150TIME	e .			Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequence of):	JV 1000	7 300 000	•		_	beens
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	Box eath cert attendin for use	Physician/M	in the past 12 months?		2 Fetal death 3	Ectopic pregnancy	у		23d. Date Mon	of deliver	y Day Year
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	ds, P.O.  uires that the d signed by the d be detached		Part II. Other significent conditions co	ntributing to death b	out not resulting in the	underlying cause giv	ven in Part I.	23e. Did tot	bacco use contri	bute to the	e cause of death?
	Division of Vital Records, tor Attending Physician: The law requires to after death. Diractor: After this certificate has been signed in by the tuneral director, page 2 should be or	Completed by	Renel Fail	WR				1 □ Y €	es 2 🗆 No	3 🗌 Proba	bly 4 Anknown
	K requ	ete	1 Nec dunt	in acti	~ ^			24a. Was a	n 24h W	lere auton	sy findings available
	Vital Re iician: The lav certificate has rector, page 2	d m	The good	~ ! !!!	Y \			autops	ned? pr	ior to com	sy findings available ipletion of cause of
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	of Vita Physician: this certific	o Be	examiner?	lospital: 1 Inpatie	ent 2 ER/Outpatie	ent 3 DOA Oth	26. Place of Death	me 5 ☐ Reside		. (0%	
	Of Physer this eral of	n: To	27. Manner of Death	28a. Date of Inju (Month, Da				28d. Describe ho			
	ion nding ith. : Afte	io	Accident 5 ☐ Pending investigation	(Month, Da	y Year) Injury		rk? ]Yes 2 □No				
	ViS Attar	ifica	3 Suicide 6 Could not be determined	28e. Place of Inj	jury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (St	reet and Numbe	r or Rural	Route Number,
	Disafter safter al Dir	Certification;	- I Homicide	building, et	ic. (Specify)			City or Town	i, State)		
	Division of Vita Within 24 hours after death. To the Funaral Director: After this certific geompletely filled in by the funeral director.	Medical	29a. Certifier (Check only one) CE Certifying Phy 2	sician: To the best ner: On the basis o and manner st	of my knowledge, dea if examination and/or i ated.	th occurred at the tinnvestigation, in my o	me, date and place, a opinion, death occurr	and due to the ca ed at the time, da	ause(s) and man ate and place, a	ner as sta nd due to	ited. the cause(s)
	To th Withir	W	29b. Signature and title of certifier			29c. Licens	se number	25	9d. Date signed	(Month, E	Day, Year)
	od'	1	* 0 >	5 >	10.	Y	LS-DD		Man	29	,2005
	10		30. Na nd address of person	_	eath (Item 23a) (Type	Print)		) ( )	0	2.0	
	( -		Deiny y. Ware		2401 W	1. Belvec	rere; t	Sultiv	rare, 1	ND	11179
	Sta Regist		31. Date filed (Mooth Day, Year)	ו 32. Hagistr	rar's Signature		.00		15		
			JU	M UNIX ZUUS	Med e	and the	00 -				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year Michae JUN C 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MD If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. BARTIMORE COUNTY HOSPITAL 6. Sex CONSTER NORTHWEST **Funeral** Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**/2** M 2□ F 217-64-6280 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahov M Completed by Funeral Director 1 Yes 2 No JALM MORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21244 Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married other traumatic avent, the Medical Every Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Blac Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Docurdet Ed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James 2 COUR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Roule Number, City or Town, State, Zip Code) item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Heville 20a. Method of Disposition Date 20c. Location -Department of Important: If it any injury or o ō 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Grove Noth. Ch. am ville MP 22. Name and Address of Facility
2325 VORK Timonium, MD 21093 21. Signature/of Funeral Service Lice RD EFULALTERNATIVE FUNERAL + CREMATION CENTER 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** preumoni disease or condition resulting in death) /Medical to (or as a consequence of) Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy 2□No 2 No 25. Was case referred to medical

Be Completed funeral director, Certification: To filled in by the

this

After

death.

after death Director: /

24 hours a

within 24

examiner 1 Yes

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

Medicai

4 Homicide

(Check only one)

2 🗌 No

e of Death (C	heck only one)	
ursing Home	5 🗆 Residence	6 □Other (Specify)
28d	Describe how ini	ury occurred

Other: 4 N 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

26. Plac

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

5401 Old Court Road, Kandallstown M.D . Registrar's Signature

State Registrar

JUN 0 7 2005

5 Pending

investigation

6 Could not be determined



			1 - For State Registrar	State of Ma		d / Depa	artment o	f Health	and Me	ental Hyg		TUUD -	18961
	Physici		1. Decedent's Name (First, Middle, Last)  Addie Elizab	eth Joh	nsor	1				2. Date of Dea June 1		2005 Year	3. Time of Death 9:30 A.
	/Medic Examin		4a. Facility Name (If not institution, give s Future Care /Old				4b. City, Tow Randal	n, or Location				County of Death Baltir	
	Funeral Director			M X□F 7. Age	(In yrs. la 97	est birthday) Yrs.	If Under 1 You Months Da	ear If Under ays Hours	Min.	8. Date of Birth (Month, Day Nov. 2	Year)	9. Birthp Coun 1907 Maj	lace (State or Foreign try) cyland
pooloop	show	or	Usual Residence of Decedent  10a. State 10b. County  Maryland N/A		10c. City	, Town or Lo	cation Baltim	0.20				11	0d. Inside City Limits
de deix	a or 28a-1	Direct	10e. Street and Number 5220 York Road				10f. Zip Coo			1		tizen of What Coun	
oo office don't	penim. Tages I and a should be line within 2 hours are used with the waryand Department of Health and Mental Hygiene. Inportent; or Hems 23a or 28a-f show any injury or other treumatic event, the Mudical Examinal must be nutilised at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married	2. Was Decedent E Armed Forces? 1  Yes 2 N				of Hispanic O Cuban, Mexica		cify Yes or No- lican, etc.)		14. Race - Americ Black, White, of Special 1acl	etc.
700-C12	e. an "netural" Modical Ex	Completed b	3 ☑ Widowed 4 □ Divorced  15. Decedent's Educ (Specify only highest grade  Elementary/Secondary (0-12)	Year or Dates: cation completed) College (1-4or 5-	+)	16a. Dece (Give life.	dent's Usual Od kind of work do OO NOT use re	ccupation one during mo etired)	st of working	g	16b. K	and of Business/Inc	
	intal Hygien ed other th e event, the	Be	12th grade  17. Father's Name (First, Middle, Last)  Aquilla Johnson	<u> </u>		LPN		1		\$ (First, Middle, 10mpso	Maiden	te of Ma Sumame)	aryland
Mary	alth and Me	To	19a. Informant's Name/Relationship (Туд Linda Chinnia/ E	oe, Print)		19b. Mailir 5206	ng Address <i>(Sti</i> Kenil	reet and Numb	er or Rural	Route Number	, City o	or Town, State, Zip re, Mary	Code) 21212 Land
	nent of Hean		20a. Method of Disposition	emoval from State	20b. Pl. ce Mary	ace of Dispo metery, crei vland	sition (Name o matory or other Natic	p <sub>place)</sub>	6/6/0 em. 1	5 Pk L		ocation - City or To rel, Maj	
	Departr Departr Importe any inj		21. Signature of Funeral Service/License	e Ma		22	2. Name and Ad	ddress of Facil	ityChat	tman-H			eral Home ,Md21215
	hysician /Medical Examiner	er	23a. Parl 1. Enter me disease, or complications, or heart failure. List only on immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	Due to (or as a	re / consequ	ence of):	er the mode of	140			est,		Approximate Interval Between Onset and Death
UNISION OF VICE TO VICE TO US OF SOLUTION	physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequ	ence of):							
C. DOX	y the attending phy ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal	death 3	Ectopic pregna Other (specify					23d. Date of delive Month	ry Day Year
COIOS, T	been signed by the a should be detached to	by	Part II. Other significant conditions con			-	nderlying cause	e given in Part	l.	23e. Did to		use contribute to th ⊠No 3 ☐ Proba	e cause of death?
The law of	cate has be	Completed								24a. Was a autops perform	v	death?	osy findings available inpletion of cause of
Diversions	After this certificate has funeral director, page 2	To Be	1 163 4 100	ospital:		R/Outpatier	_	Other: 4 X N	ursing Hom		ence	6 ☐Other (Specify	)
	ar death.	Certification:	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day) 28e. Place of Inju		28b. Time of Injury	М	Injury at Work? 1 DYes 2 Dice	]No	3d. Describe ho		ry occurred  nd Number or Rural	Route Number.
	within 24 hours after death.  To the Funerel Director: A completely filled in by the fu	al Certi	4 Homicide  29a. Certifier  1 Certifying Phys	building, etc.	. (Specify,				nd place, ar	City or Town		·	ated
od od	within 24 hours after To the Funerel Dir completely filled in	Medical	(Check only 2 Medical Examin	er: On the basis of and manner stat	examinati ed.	on and/or in	vestigation, in r	ny opinion, de	ath occurred	d at the time, d	ate and	d place, and due to	the cause(s)
۴	3 - 8		12/10	111			D	003337	0		6	13/05	
	2		30. Name and address of person who con	mpleted cause of de	ath (Item	23a) (Type,	Print) N. Ga	Ivert,	1	Bu/10.	1	11. 2/2/8	4
	Sta Registr		31. Date filed (Month, Day, Year)  JÜN 0	mpleted cause of de	Signati	J. J.	Spare	W.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month ARL **Physician** 13:05 M JUN 03 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner OF MARYLAND MEDICAL CENTER BALTIMORE UNIVERS ITY 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 6. Sex **Funeral** Hours 1₩ 2□ F mi 219-52-5164 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ? is marked other than "natural", or Items 23s or 28s-f shov traumatic event, the Medical Examinar must be mutified at 1.☐¥es 2 ☐ No Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21223 Lombard 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? t 1. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☑ Divorced Completed by 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within hand Mental Hygiene.
7 is marked other than "! Elementary/Secondary (0-12) College (1-4or 5+) Balto. Equipment Operator NA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Irene Dorsey Kelly, SR.

19a. Information's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 is Ho Brothe. 1133 W. Lambart Kell, 20a. Method of Disposition other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State reen Mant Cemeters 10-603 129 12 22. Name and Address of Facility 119-121 5, Stricker St (Salto MI) 4 ☐ Donation 5 ☐ Other (Specify) Balto MD 21. Signature of Funeral Service Licenses ntegritu 21253 tuneral 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fig. Approximate Interval Between Onset and Death PNEUMONIA Immediate Cause (Final days **Physician** disease or condition resulting in death) /Medical Bacteremia 5thep tocals Prevmontal **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Compieted by Physician/Medical Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Datitic Due to (pr as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? res 2 No 1 ☐ Yes 2 ☐ No 1 | Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 No 28d. Describe how injury occurred the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director; 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funeral Direct completely filled in by determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 03 2005 Name and address of person who completed cause of death (Item 23a) (Type, Pnnt) Baltomore, MD 5tree Greene 31. Date filed (Month, Day, State Registrar

Kolstrom, Raymond

Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Brick Mason 17. Father's Name (First, Middle, Last) 12 should be fill h and Mental H Gustav Adolph Kolstrom Helmi Laitinen 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Importent: if item 27 is m any injury or other treum Mrs. Irene E. Kolstrom (wife) 5401 Forge Rd., White Marsh, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 □ Burial 2 X Cremation 3 □ Removal from State Bayview Crematory 6/8/2005 ' 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Physician /Medical Due to (or as a consequence of): **Examiner** pona tremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Examiner burial-transit Hnemia Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. Be Completed by 24a. Was an autopsy performed 2 No Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No ို 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Division 1 Natural 5 Pending investigation 1 🗌 Yes 2 No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide within 24 hours a To the Funerel [ 29a. Certifier Medical To the 29c. License number 29b. Signature and title of certifier D0058631 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR ISheRING Amdo 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Raymond Kolstrom 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Square Ba Himore Hospital Center Kosedale Franklin If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 1**/2** M 2□ F 214-22-6804 Director March 23, 1928 New York Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23e or 28a-f sho other treumatic event, Ir a Mcclical Examinar result by multified at 1 ☐ Yes 2 No Be Completed by Funeral Director Maryland Baltimore White Marsh 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 5401 Forge Road 21162 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: WW 11 1 Never Married 2 Marned 1 ☐ Yes 2 No Specify: White Specify: 16b. Kind of Business/Industry Commercial Construction 18. Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes Approximate Interval Between Onset and Death /week 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 9000 FRANKLIN SQUARE DR. BAITIMORE Md. 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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		•	For State Registrar		·· <b>,</b> ···		rtificate					Reg. No.	UD	18964
			1. Decedent's Name (First, Middle, L	ast)							2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physicia /Medic		ESTHER MARY KLO	TZ							JUNR	4, 200	05	12:20 A.M
	Examin	er	4a. Facility Name (If not institution, ga			137	4b. City, To						nty of Death	I.P.
			GENESIS ELDERCARE  5. Social Security Number 6.		ge (In yrs. la		If Under 1		KVILL If Under 2		8 Date of Birth		JTIMOR	
	Funeral Director		213-38-5425		93	Yrs.		Days	Hours	Min.	8. Date of Birth (Month, Day 5/20/19	12 Year)	MARY	place (State or Foreign ntry) LAND
	D		Usual Residence of Decedent											
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9	or life	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐	M∕o		1 ☐ Yes 2[		Specify:	.,		Spec	ifv.	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or liems 23e or 28a-f ehow than Marical Examitier hald be notified at	ed by	3X Widowed 4 □ Divorced  15. Decedent's	Year or Dates		16a Dece	dent's Usual	Occupa	tion			16b. Kind of	W	HITE
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	be filed tal Hygi d other event, t	Bec	17. Father's Name (First, Middle, Las	it)							(First, Middle,	Maiden Sum	ame)	
yla	ould hard	၉	WILLIAM MURRAY						LOUI			O: -		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depurtment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It a Modical Examiner man be notified at once.		19a. Informant's Name/Relationship  JOAN SCOVILL/DAI				ng Address (: 6 FRAN				I Route Numbe			D 21156
	theal tem 2 other		20a. Method of Disposition	, G111 D1 (	20b. P!	ace of Dispo	sition (Name	e of	1		ate	20c. Location		
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			1 - For State Registrar		aryland / Depa		of H	ealth a		_		05	1896	5
ı	Physic	ian	Decedent's Name (First, Middle, Last							2. Date of Death Month	Day	Year	3. Time of De	ath
	/Medi	ċal	Hazel		nox	1				June	ı	2005	2001	М
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	Funeral		5. Social Security Number 6. Se		e (In yrs. last birthday)	If Under 1		Nore If Under 2	24 Hrs.	8 Date of Birth		N/A	lace (State or Fo	raian
	Director			M 2000	99 Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, March 6.		Coun	try)	reign
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	darylan show	20		/ A	10c. City, Town or Lo	Balti	more	<u>,</u>				10	0d. Inside City L XIK∏Yes 2[	
	28e-1	Director	10e. Street and Number			10f. Zip (				10	- 0:::			1140
	3a or	Ö	3939 Roland Ave	nue Apt.	803	TOI. Zip C		.211		10	g. Citizen of	What Coun	try?	
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36	or Ite	/Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 24□X If Yes, Give	No	1 Yes, specit 1 □ Yes 🐰			, Puerto F	lican, etc.)		ack, White, e	etc.	
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Maryland 21215-0036	C) a m 0		19a. Informant's Name/Relationship (T) Helen Hoffman	pe, Print) (Niece)	19b. Mailir	g Address (	Street ar	nd Number	or Rural	Route Number, Hampste	City or Town	n, State, Zip (		
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	To the Hospitel or Attending Physicien: The law within 24 burus after death.  To the Funeral Director: Atten this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier (Check only one)  Certifying Physical Exemination (Check only one)	Ician: To the best of er: On the basis of and manner sta	of my knowledge, death examination and/or inv ted.	occurred at estigation, in	the time, my opin	date and lion, death	place, an occurred	d due to the caus at the time, date	se(s) and ma and place,	anner as stat and due to t	ted. he cause(s)	
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4	•		30. Name and address of person who co	npleted cause of de	Path (Item 23a) (Type, F	Print)	siti	, PA	nKi	NAY BO	4)+N	102	1218	
**	Sta		31. Date filed (Month, Day, Year)	32. Registra				1		1	( , ,	- 1		
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**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 8966 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** June 1,2005 Daisy Mae Kent 2: 44 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Good Samaritan Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 12–25–1922 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2X F South Carolina 82 Director 577-90-7361 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r Itams 23a or 28e-f show **Baltimore** NA 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21217 1214 Eutaw Place death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ö 1 ☐ Yes 2 No Maryland 21215-0036 Specify: ir than "natural", o 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homes Domestic 8 s 1 and 2 should be filed w f Health and Mental Hygier item 27 is marked other tl other traumatic event, the 18. Mother's Name (First, Middle, Maiden Sumame) unknown 17. Father's Name (First, Middle, Last) unknown Be ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 N. Calvert Street Baltimore, MD 21201 nt of Health a :: If item 27 is or other tra Renee Alexander/ Guardian Baltimore, 20a. Method of Disposition
1 △ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 Department of Importent: If any injury or once. 06-07-05 lansdowne, MD Mt. Zion Cemetery 4 Donation 5 Other (Specify) permit. 21. Signature of Funeral Service Lices 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor St. Balto, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ardiac rollythma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence Examiner Hospitel or Attanding Physician: The law requires that the death certificate be executed nding physician and use as the burial-tran resulting in death) Last Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant atter 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 🗖 No Ö 9 Unknown 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 1 ☐ Yes 2 ☐ No 4 DUnknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2□ No certificate 1 Yes 1 ☐ Yes ector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only of Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA ÷ j P 1 Tes 1 Inpatient this 28b. Time of 27. Manner of Ceath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: Natural 5 Pending investigation 1 Tyes 2 🗆 No death. 2 Accident Diractor: , 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 4 - Homicide within 24 hours af To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature, and title of certified D 25391 Cavan Blud, Paltimore MD 21239 30. Name and address of person who completed cause of death (Item 23a) (Type Print) 5 60 31. Date filed (Month, Day, Year) Registrar's Signature State JUN 0 Registrar

		1 - State of Maryland / E	Department of H			ene 005	18967
Physicia		1. Decedent's Name (First, Middle, Last)  200E   KIENAE			2. Date of Death Month	Day Year	7/ 9/ 04
/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	r Location of Death		4c. County of De	
		Anne Arendel Medical Centre	Anna	poles		Anne A	
Funeral Director		5. Social Security Number  354-01-0472  Usual Residence of Decedent	thday) If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) . (	rthplace (State or Foreign Jountry) 111nois
yland yland		10a. State 10b. County 10c. City, Town	n or Location				10d. Inside City Limits
ith the Marylan or 28a-1 show	ctor	MD Anne Arundel Ann	apolis				1 ☐ Yes XXNo
with th	Funeral Director	10e. Street and Number	10f. Zip Code		10	g. Citizen of What C	country?
eath v	eral	130 Hearne Road, #205  11. Marital Status  12. Was Decedent Ever in U.S.		1401 ispanic Origin? (Spe	acify Yes or No-	USA 14. Race · Am	erican Indian
Ind. 2 12 13-0030 be filed within 72 hours after death with the Maryland Haylgiene. do ther than "natural", or items 23a or 28a-f show event, I're Modical Examinar must be notified at	by Fun	Armed Forces?  1 Never Married 2 Married  1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 1 No	Specify:	Rican, etc.)	Black, Wh	
72 hours natural;	Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupa	ation during most of worki	na la	6b. Kind of Busines	s/Industry
ithin 7	mple	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired	d)	, ig		
Hygier ther ti		12 Ho	memaker	18. Mother's Name	(First Middle M	Own Home	
ges 1 and 2 should be filed within 72 hr of thealth and Mental Hygiene. If item 27 is marked other than "natur or other traumatic event, the Madical	o Be	Nels M. Olsen			Nelson		
should is marke iumatic	-	19a. Informant's Name/Relationship (Type, Print) 19b	. Mailing Address (Street	and Number or Rura	I Route Number,	City or Town, State,	Zip Code)
and 2 ealth a m 27 is			36 Valleywoo				
Pages 1 nent of He int: If iter ury or oth		1XXBurial 2 ☐ Cremation 3 ☐ Removal from State	Disposition (Name of ry, crematory or other plac	:e)	l l	Oc. Location - City o	
t. Pacrtmen rtmen rtant: njury		'4 □ Donation 5 □ Other (Specify) Park1		6/4/		Rockv <b>i</b> lle	, MD
permit. Pages 1 and 2 Department of Health a important: If item 27 is any injury or other tra		21. Signature of Funeral Service Licensee  Octuber A Colonia	Hardesty LZ Ridge			A. lis, MD 2	1401
		23a. Part1. Enter the dise of or complications that caused the death. Do r shock, or heart failure. List only one cause on each line.	not enter the mode of dying	g, such as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	adores				
Examiner		Due to (or as a consequence of	anterl				
72 =	ner	Sequentially list conditions, if any leading to immediate Due to (or as a consequence)	of): /	0	1.		
ate be executed hysician and the burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence or	pheral vo	sulor	Lease	2	
		Due to (or as a consequence of	л):				
ficate ficate physis the	edical	d		·			
The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Festal death	3 □Ectopic pregnancy			23d. Date of de	alivery
ed for	sicia	1 Yes 2 No 4 Pregnant at time of death	5 Other (specify)			Month	Day Year
that the de ed by the a	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in	the underlying eauce any	on in Part I	23e Did tob	acco use contribute	to the cause of death?
signed d be det	d by	CHE SUR actions	tenon	en in ranti.		- 1 -	robably 4 Unknown
w require been si should I	lete	CAO			24a. Was an	24b. Were a	utopsy findings available
The lav	Completed	106			autopsy perform	ed? prior to	completion of cause of
rician: The certificate rector, pag	0	25. Was case referred to medical		26. Place of Death			S 2L NO
hysician: his certifica	To B	examiner? 1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Ou	tpatient 3 DOA Othe	er: 4 🗆 Nursing Ho	me 5 🗆 Resider	nce 6 Other (Sp.	ecify)
ding Ph h. After th funeral	on:	1 Natural 5 Pending (Month, Day Year) II	Time of 28c. Injury	k?	28d. Describe how	v injury occurred	
ttend death ctor: / the f	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa		Yes 2 □ No	28f Location (Str	eet and Number or F	Rural Route Number
after after of Direct of in by	Certification:	4 Homicide determined 200. Flace of Injury Actionis, la building, etc. (Specify)	ini, street, factory, office		City or Town,		and riodio runnos,
To the Hospital or Attending Physicien: within 24 hours after death To the Funeral Director: After this certifics completely filled in by the funeral director.	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated.					
To the Within To the	Me	29b. Signature and title of certifier	29c. License	e number	29	d. Date signed (Mor	th, Day, Year)
		1/mder	Do	057994		6/1/05	
10		30. Name and address of person who completed cause of death (Item 23a) (					ma pols M02140
Sta Registr		31. Date filed (Month, Day, Year)  JUN 0 7 2005  32. Registrar's Signature	Sperke	- 0			

			1 - State of Maryland / Department of Health and Mental Hygiene Certificate of Death  State Registrar  State of Maryland / Department of Health and Mental Hygiene 5 18968												
ı	Physici		1. Decedent's Name (First, Middle, Last)  Julia C. Kiamos							2. Date of Death  Month  June 1,		005	3. Time of 9:35	f Death A M	
	/Medio Examir		4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death					County of Death			
	ZXXIIII		Shady Grove Adventist Hospital				Rockville				Montgomery				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Importent: If item 27 Is marked other then "neturel", or Iteme 23a or 28e-f show any injury or other treumetic event, the Marical Estamination untilled at one		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 084−07−2268 1				Months Days Hours Min				8. Date of Birth (Month, Day, Year) 9. Birthplace (State or F				
		ctor	084-07-2268 Usual Residence of Decedent	Feb. 8, 1916 New York					York						
			10a. State 10b. County		10c. City, Town	or Location							10d. Inside C	ity Limits	
			New Jersey Atlantic Dorothy 1欠 Yes									1 <b>½</b> Yes	2 🗌 No		
		Director	10e. Street and Number			10f. Zip						zen of What Cou	intry?		
		rail	51 Cape May Avenue									nited States			
39		by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 41 ☑ Divorced  12. Was Decedent Ever in U. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:			<ol> <li>Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica</li> <li>□ Yes 2 ☑ No Specify:</li> </ol>					es or No- etc.)  14. Race - American Indian, Black, White, etc.  Specify: White				
2-0		Completed	15. Decedent's Education 16a. Decedent's Usual (Specify only highest grade completed) (Give kind of work					ation	t of workin		16b. Kir	. Kind of Business/Industry			
2		nple	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Give kind of work done during most of working life. DO NOT use retired)  Plastic  Ouality Control Inspector  Manufacturing												
2				201)	Qua	lity Co	ntro					ıfacturi	.ng		
anc		Be c								ne (First, Middle, Maiden Sumame) a Turkovitch					
$\mathbf{Z}$		2	19a. Informant's Name/Relationsh		19b. A	Mailing Address	(Street a					Town, State, Zi	p Code)		
Z			Polly Kiamos/Da	ughter								ntown, M		4	
ore,			20a. Method of Disposition	0 TD 14 00	20b. Place of D	isposition (Nan crematory or o	ne of ther plac	e)		ate 6	20c. Lo	cation - City or T	own, State		
<u>Ĕ</u>			1 ⊠ Burial 2 ☐ Cremation  1 4 ☐ Donation 5 ☐ Other (Sp	_	St. Ber Cemete	crematory or o rnard's ry	·		June 200	05'	Doro	Dorothy, New Jersey			
Baltimore, Maryland 21215-0036			21. Signature of Funeral Service L	icensee	M00198	Robert 7557 Wis	A Addres A. I scons	S of Facility Sumphi Sin Av	rey F	uneral Sethesd	Hom a, M	e/ <sup>Bethe</sup> Char D 20814-	sda-Che se, Inc -3501	evy C.	
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		23a. Part 1. Egrer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between												
			Immediate Cause (Final disease or condition	Res	piratory F	ailure							Onset and I	Death	
			resulting in death)	Due to (or as a consequence of):											
		Į.	Sequentially list conditions,	b	b										
		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Ursease or injury that initiated events												
oʻ			resulting in death) Last	C. Due to (or as a consequence of):											
8760,		dical	1	d											
Box 68		an/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy						2	23d. Date of delivery  Month Day Year			
o.		Certification; To Be Completed by Physician/Me	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	at time of death	of death 5 Other (specify)					Month Day Ye					
rds, P			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown					
Records,										24a. Was a autops perfor	sv	24b. Were auto prior to co death?	opsy findings a	available ause of	
a			25. Was case referred to medical							1 Tes	2 🔀 No	1 ☐ Yes	2□ No		
Vital			examiner?  1 \sum Yes 2 \sum No	Hospital:	itient 2 ER/Outp	atient 3 DO	Othe			(Check only or		Other (See	£.1		
n of			27. Manner of Death 1 ☑ Natural 5 ☐ Pending							me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred					
sio			2 Accident investigation inves	ation of he	M 1 ☐ Yes 2 ☐ No										
Division		ertifi	4 Homicide determin	286. Place of				28	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
		edical C	29a. Certifier  (Check only one)  1 Street Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										)		
		Me	29b Signature and title of certifier				29c. License number 2				9d. Date signed (Month, Day, Year)				
}							D0061681				June	June 1, 2005			
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Robert D. Kirkcaldy, M.D. 9901 Medical Center Drive, Rockville, Maryland 20850												
			Robert D. Kirke				nter	Driv	ze, R	ockvill	le, 1	Maryland	1 20850	)	
	Sta Registr		31. Date filed (Month, Day, Year)  JUN 0 7 2005  33 Registrar's Signature												

			•	State of Maryland / Department of Health  1- State Registrar Certificate of Death			iene 00	5	18969
		hysicia	an l	1. Decedent's Name (First, Middle, Last)		2. Date of Deat	h	Yeer	3. Time of Death
		/Medic	al	Warren L. Keller  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location	on of Death	June 5	, 2005 4c. County o		1:45 pм
		Examin	er	Gilchrist Center Towson	on or Death			imor	re
		ineral rector		5. Social Security Number  6. Sex  1 M 2 F  7. Age (In yrs. last birthday)  Months  Days  Hours	der 24 Hrs. s Min.	8. Date of Birth (Month, Pay, Varch 16,	<sup>Y</sup> 1913	9. Birthpl Coun VEII	place (State or Foreign http:)
	and	MC T	}	Usual Residence of Decedent         10c. City, Town or Location           10a. State         10b. County         10c. City, Town or Location				1	0d. Inside City Limits
	Mary	a-faho	tor	MD Baltimore Towson					1 ☐ Yes 2 ☐ No
	ith the	or 28,	Funeral Director	10e. Street and Number 10f. Zip Code		1	0g. Citizen of Wi		itry?
	eath w	18 23a	era	134 Marburth Avenue 21286  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic C	Origin? (Spec	ofu Voc or No	U.S.A.		an Indian
	<b>)36</b> ırs after de	it, or Itam Xeolner	by Fune	11. Marital Status  1  Never Married 2  Married	can, Puerto R	lican, etc.)		White, o	etc.
ì	<b>5-0</b> (	nature	eted	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during m	ost of working	a	16b. Kind of Bus	iness/Inc	dustry
	Maryland 21215-0036 nd 2 should be filled within 72 hours aft Ith and Mental Hygiene.	ar than "	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  12  (Give kind of work done during mellife. DO NOT use retired)  Salesman			Wholesa	le F	lumbing
	ind be file ital Hy	evant	Be			(First, Middle, M	Maiden Sumame	•	
•	iryla should nd Mer	marke	ပ	William H. Keller  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Num.	Rachel	Route Number		ren	Code)
	Ma Ind 2 s aith ar	ar treu		Arline M. Keller-wife 134 Marburth Aven			1D 2128	_	3333,
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	nt: If itam rry or oth		20a. Method of Disposition 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Comparison of Disposition (Name of cemetery, crematory or other place)  Comparison of Disposition (Name of cemetery, crematory or other place)  Comparison of Disposition (Name of cemetery, crematory or other place)	6/9/05		20c. Location - C Timonium		wn, State
2 5	Balti permit. Departm	Importe any inju once.		21. Signature of Funeral Service Licensee Utilliam G. Dau 22. Name and Address of Factorial 1050 York Rd., 7				me, ]	Inc.
				23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.					Approximate Interval Between
		sician edical		Immediate Cause (Final disease or condition resulting in death)  a	CAN	cer			Onset and Death
		miner		Due to (or as a consequence of):					Ü.
9		.=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter timoscrying.					
101	ecuter	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
0/0	<b>68760,</b> 1	physician and is the burial-transit		d					
100 S	x 68 ertifica	ding ph	Med	IF FEMALE:					
9 (	O è	the attending ploped for use as t	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown			23d. Date Mont		ny Day Year
2	IS, P.	signed by the	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par	ırt I.	23e. Did tob		oute to th	ne cause of death?
5	Records,	s need s	eted			24a. Was ar			psy findings available
	Re The lay	certificate has rector, page 2	Completed			autops	y pri ned? de	or to con ath?	npletion of cause of
3		ertifica actor, p	Bec	examiner?	ace of Death	(Check only one			
	P &	this aldi	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ I		e 5 Reside	nce Other	(Specify	) Hospice
E.	On nding	r: After e fune	ation	27. Manner of Teath  1 Natural 5 Pending (Month, Day Year)  28a. Date of Injury 28b. Time of Injury at Work?  2 Accident investigation  28c. Injury at Work?		od. Describe no	William Coopers		
eller,	Division of or Attending after death.	Diractor	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28	3f. Location (Str City or Town	reet and Number , State)	or Rural	Route Number,
X	Division  To the Hospitel or Attending within 24 hours after death.	To the Funerel Diractor: After this certificate hi completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, do and manner stated.	and place, ar death occurred	nd due to the ca d at the time, da	use(s) and man ate and place, an	ner as sta	ated. the cause(s)
	To th within	To th	Me	29b. Signature and title of certifier 29c. License numbe		29	d. Date signed	Month, I	Day, Year)
				If the they they, und Dass			lune	L	
	12	11		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			Charles MD 2120		eet
		Sta		31. Date filed (Month, Day, Year)  32. Posistrar's Signature		OWSUII,	<u> 4120</u>	1	
		Registra	ar	JUN 0 7 2005 Seven & Spark					

					State of Ma							ble.	
١,				For State Registrar			Certific				Reg. No.	05	18970
30		Physic /Medi		1. Decedent's Name (First, Middle, La Benjamin T.	st) Krusnie	ewski				2. Date of De Month June	Day	Year 005	3. Time of Death $11:35P^{\text{M}}.$
11:		Exami		4a. Facility Name (If not institution, giv HCR-Manor Care					or Location of Dea		4c. County	of Death	
		Funeral		5. Social Security Number 6. S		je (In yrs. la		Roseo		s. 8 Date of Bird	Balt		
at	301	Director		215-01-7301 1	X M 2 F	89	Yrs. Mon	ths Days	Hours Mir		, 1915	Mar	lace (State or Foreign try) yland
1 6	7	nyland how		10a. State 10b. County		10c. City,	Town or Location					10	0d. Inside City Limits
200	D	the Maryland 28e-f show	ector	Md. n/a		Ва	ltimor	e					1 XYes 2 No
7	7	with a or	Funeral Director	10e. Street and Number 732 South Poto	omac Stre	eet	10f	Zip Code 2122	) /.		10g. Citizen of W	Vhat Count	try?
40'	2/2	death	nera	11. Marital Status	12 Was Decedent 8	Ever in II S	13. Was D			Specify Yes or No- rto Rican, etc.)	USA 14. Race	e - America	an Indian.
N)	36	hours after ural', or ite	by Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	No		specify Cub s 2X No		rto Rican, etc.)		k, White, e	etc.
5	5-003	2 hour	ed b	3 ☑ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:		16a. Decedent's				Specify.	Wn1	
5		within 72 ene. then "nat	Completed	(Specify only highest gra	de completed)  College (1-4or 5		(Give kind o life. DO NO	f work done T use retire	during most of wo d)	orking	16b. Kind of Bu	siness/Ind	ustry
5	5.	e filed within al Hygiene. other then "vent, the Me	Co	Elementary/Secondary (0-12) 8 t h  17. Father's Name (First, Middle, Last)			Mea	at Pa			Esska		
! )	land	ould be f Mental P arked of	To Be	Timothy Krusni						me (First, Middle, abeth We		e)	
4	Maryland	2 should by and Menta Is marked eumatic ev	F	19a. Informant's Name/Relationship (7			19b. Mailing Add	ress (Street		ural Route Numbe		State. Zip (	Code)
Cont		12 g g		Robert Krusniew	ski (sor	1)	618 S.	Stre		reet Ba			
Ă	Jore	Pages 1 ar		20a. Method of Disposition  1X☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	сеп	etery, crematory	or other pla	ce)	Date	20c. Location - (	City or Tow	wn, State
1	Baltimore,	1. fr 55 15		<ul><li>'4 ☐ Donation 5 ☐ Other (Specify</li><li>21. Signature of Funeral Service Licen</li></ul>		St.	Stanis		, -	9/05 I	Baltimo	re,	Md. Home,PA
さ	ã	Depa Impo any ir		Fold from			1201	Dun	dalk Av	ve. Balt	timore,	Md	21222
N				23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused one cause on each lin	the death.							Approximate Interval Between
3	-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Bla	dde		ner	,				Onset and Death
Š		Examiner			Due to (or as a	a consequer	nce of):						
		D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	a consequer	nce of):		- A				
Č	V	ecuter and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	Vgo	one	ط	eehm				
3	760,	eath certificate be executed attending physician and for use as the burial-transit	calE		Due to (or as a	a contequer	nce of):	Jun	E PI	sear			
Q	89	rtificate ng phy as the	Medic		a		Over						
2	Вох	ath cer ttendir or use	lan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o	of pregnancy 2  Fetal de		c pregnancy				of delivery	,
0	0.	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physic	1 Yes 2 No	4□Pregnant at t 9□Unknown	time of deat	h 5 ☐ Other				Mont	th D	Day Year
0	ď.	es that igned b	by PI	Part II. Other significant conditions co	ntributing to death bu	it not resultir	ng in the underlyin	g cause give	en in Part I.	23e. Did tol	bacco use contrib	bute to the	cause of death?
	of Vital Records,	w require been sig should b	ted t	Hement	L.					1 □ Y€	es 2□No 3	3 🗌 Probat	bly 4 ☐Unknown
Y	3ec	has by	Completed							24a. Was a autops	n 24b. W	ere autops	sy findings available pletion of cause of
2	Tal	ician: The I certificate ha rector, page	e Col	25. Was case referred to medical						perform 1 Tes 2	2 No 1	eath?	
ヹ	N N	lysician; is certific director,	To Be	examiner?	Hospital:	nt 2 TER	Outpatient 3	DOA Othe		ath (Check only on ome 5 ☐ Reside		- /0 // 1	
9		ding Phys n. After this funeral di	on: 1	27. Manner of Death 1   Natural 5 □ Pending	28a. Date of Injury (Month, Day	/ 28	b. Time of Injury	28c. Injury Work			ow injury occurred		
SPI	Division	Attending r death. sctor: After	icatl	2 Accident investigation 3 Suicide 6 Could not be			M	1 🗆 '	Yes 2 □No				
0	É	al or Atten s after deatl 1 Director: d in by the	Certification:	4 Homicide determined	28e. Place of Injur building, etc.	ry · At nome . (Specify)	, farm, street, fact	ory, office		28f. Location (St. City or Town	reet and Number n, State)	or Rural F	łoute Number,
				29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medical Exami	sician: To the best of ner: On the basis of e	f my knowle	dge, death occurr	ed at the tim	e, date and place	, and due to the ca	ause(s) and mani	ner as stati	ed.
V		ithin 2, o the 1	Medical	one)  29b. Signature and title of certifier	and manner state	ed.		29c. License					
		- s ⊢ ŏ		· acus	2	r	10		31464	25	9d. Date signed (	0 J	y, rearj
	-	10	1	30. Name and address of person who co	mpleted cause of dea	ath (Item 23		5 5		Smte 3	a D Ra	Jh.	noc my
		Stat	e	31. Date filed (Month, Day, Year)	32. Registrar	r's Signature	2(N.	cuto	m ar	onles	0 4 0 364	uq m	21201
		Registra		JUN 0 7 20		14	1.	64.					

DHMH 17 Rev 1/2001

			1 - For State Registrar		laryland / Depa	artment o		nd Mental I	Hygiene Reg. No.	005	189	71
	Physic /Medi		1. Decedent's Name (First, Middle, Las Helen Ann Liupaet	,		_		2. Date o Month June	Death Day 3	ž <del>v</del> o:	3. Time of 2:40	f Death P. M
	Examir		4a. Facility Name (If not institution, give 7 Willow Court	street and number	)		n, or Location of	Death		ounty of Death en Ann		
	Funeral Director		5. Social Security Number 6. Security Number 180-22-9859  Usual Residence of Decedent	¬ 14 - 2X-2X	ge (In yrs. last birthday) 75 Yrs.	If Under 1 Ye Months Da		Min. 8. Date of Month 8/25/	Birth Day, Year) 29	9. Birth Cou Penr	nplace (State o untry) 1Sylvan	or Foreign ia
	e Maryland 3e-f show lifted at	ctor	10a. State 10b. County Maryland Queen Ar	ne's	10c. City, Town or Lo						10d. Inside Ci 1 ☐ Yes	
	th with th	al Dire	10e. Street and Number 7 Willow Court			10f. Zip Cod	666		10g. Citizer USA	of What Cou	intry?	
9800	be filed within 72 hours after death with the Maryland nat hygiene. ad other then "neturel", or Items 23a or 28e-f show event, the Midrial Exam serving the mailtied at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 Tyes 24 If Yes, Give Year or Dates:	ŽNo I	Was Decedent of Yes, specify C		n? (Specify Yes or Puerto Rican, etc.		Race - Amer Black, White pecify: Whi	, etc.	
Maryland 21215-0036	od within 72 hogiene.  er then "netu , the Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 1.2		5+) (Give life. I	dent's Usual Oc kind of work do DO NOT use re maker	cupation ne during most o tired)	of working		of Business/li		
land	should be filed and Mental Hygie marked other matic event, III	To Be (	17. Father's Name (First, Middle, Last) Walter G. Romanos	ie:				s Name <i>(First, Mic</i> phine Ze]		mame)		-
Mary	s 1 and 2 should 1 Health and Men item 27 Is marke other treumatic		19a. Informant's Name/Relationship (7 Marinanne Remley)		19b. Mailin 721	ng Address <i>(Stra</i> Kent Av	e., Cato	or Rural Route Nu	mber, City or To	own, State, Zi	p Code)	
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition  1XXBurial 2 Cremation 3   14 Donation 5 Other (Specify		20b. Place of Dispo cemetery, cren	sition (Name of natory or other) 1e Vet.	clace) 6	Date /8/2005		ion - City or T sville		
Balt	permit. Departr Importe eny inji		21. Signatur Filman Service Licen:	1	10/2/0 10	30 Edille	muson A	Witzke F ve., Bal	Limore,	Home of MD 21	f Cator 228	nsvill
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each l	d the death. Do not entrine.  Composition of the control of the co	er the mode of o	dying, such as ca	ardiac or respirator	y arrest,		Approximate Interval Betwood Onset and D	ween
8760, A	death certificate be executed e attending physician and for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate rate. East thought Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):							
.O. Box 68	the death certi the attending ched for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	Ectopic pregna Other (specify)	ncy		23d.	Date of deliv		⁄ear
rds, P	sign d be	by	Part II. Other significant conditions co	ntributing to death t	out not resulting in the un	derlying cause	given in Part I.		id tobacco use		the cause of de	
al Records	The law ate has b page 2 sl	Completed						pe	as an 2- litopsy enformed?	4b. Were auto prior to co death? 1 \(\sum \) Yes	opsy findings a ompletion of ca	ıvailable tuse of
f Vital	Physicien: The this certificate har director, page	To Be	25. Was case referred to medical examiner?  1 □ Yes 2 □ No	lospital: 1 □ Inpati	ent 2 ☐ ER/Outpatient	3□ DOA	Other	Death (Check on		Other (Special	fy)	
Division of	ding h. After fune	Certification:	27. Manny of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Inju (Month, Da	y Year) Injury	M 1	Vork? □Yes 2□No		oe how injury oc			
Divi	ital or Attencus after death		4 Homicide determined	building, e	ury - At home, farm, stre c. (Specify)			City or	n (Street and No Town, State)			)er,
	To the Hospital or Attenwit in 24 hours after deat To the Funeral Director: completely filled in by the	Medical	one)	sicien: To the best ner: On the basis of and manner st	of my knowledge, death if examination and/or invaled.	estigation, in m	y opinion, death	place, and due to to occurred at the tim	e, date and pla	manner as s ce, and due to	tated. o the cause(s)	
•	To To Com		29b. Signature and title of certifier	W		296 Lice	nse number	1	29d. Date s	gned (Month, $0$	Day Year)	
	5		tavid Hale	impleted cause of c	leath (He 23a) (Type, F	acto	w,n	nd 21	601			
	Sta Registr		31. Date filed (Month, Vay, Year)  JUN 0 7 2005	32. Registr	ar's Signature		,					

			Amend  1 - State Registrar	Item#	8, pegtale	of Rightly Id	/18/1 <b>05</b> <sub>6</sub> / <sub>1</sub> Се	Artmen rtificat	t of H	lealth a	and M		jiene eg. No.	005	18972
		1	1. Decedent's Name	(First, Middle	, Last)							2. Date of Dea	th		3. Time of Death
	Physici /Medic		1/2/te	~		Lei	015					Month 06	O3	Year O 5	6:44 A <sup>M</sup>
	Examir		4a. Facility Name (If r	ot institution	, give street and i			4b. City,	Town, or	Location o	of Death			County of Deat	h
			Washingto	n Adve	entist Ho	ospital		Tako	ma P	ark			MOr	ntgomer	У
	Funeral		5. Social Security Nur	nber	6. Sex 1⊠M 2□F	7. Age (In yrs	s. last birthday)	If Under	1 Year	If Under	24 Hrs. Min.	8. Date of Birth	9/28	3/55 9. Birti	oplace (State or Foreign untry)
L.	Director		578-74-69		TIXEM 2LIF	49	Yrs.		Duyo	110013		09 28	05	Wasi	D.C.
	and *		Usual Residence of D	ecedent 10b. County		10c. C	city, Town or Lo	ocation							10d. Inside City Limits
	f sho	ō	MD		e George		Yattsv								1 ⊠Yes 2 □ No
	the 28a	Director	10e. Street and Numi					10f. Zic	Code		-	1	On Citize	en of What Co	
	be filed within 72 hours after death with the Maryland Hygiene.  d other than "natural", or items 23a or 28a-f show do ther than "natural", or items 24a or 28a-f show event. The Macified Examination in the notified at	0	6901 23	rd. Pi	Lace			701. 2.1	207	83		'			unit y r
	ms 2	Funeral	11. Marital Status		12. Was De	acedent Ever in	U.S. 13.	Was Dece	dent of Hi	ispanic Orio	gin? (Spe	ecify Yes or No-		SA 4. Race - Amer	rican Indian.
	or ite	Ē	1 Never Marrie	2 🔀 Marr	ed 1 ☐ Ye	Forces? s 2 XNo					, Puèrto	ecify Yes or No- Rican, etc.)		Black, White	e, etc.
21215-003b	hours after tural', or ite	by	3 Widowed 4	Divorced	If Yes, or Year or	Give Dates:		1 ☐ Yes	2 <u>K</u> J No	Specify:			5	Specify: B1	аск
ก	72 h	Completed	(Specify	5. Decedent	's Education	d)		dent's Usua kind of wo		ation during most	of worki	na	16b. Kind	d of Business/I	ndustry
Z	han '	mp	Elementary/Second	lary (0-12)		(1-4or 5+)	life.	DO NOT u	se retired,	)					
_	filed within 72 Hygiene. Ither than "nal		17. Father's Name (F	ings Adiabath		yrs.	Yout	h Cou	ınsel						es Inc.
_	htal hed of	Be	· ·		ŕ							(First, Middle, I		iumame)	
	should be ind Mental marked o	To	Walter 19a. Informant's Nam				10h Mailie		/Ct			ne Topps		T	
Z Z	d2s than trau		Carolyn									ille, Md			ip Code)
ย์	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic et 90.00.		20a. Method of Dispo		WIIC .	20b.	Place of Dispo					- april		ation - City or 1	Town. State
<u> </u>	ages ant of it: If i		1 ☐ Burial 2 🔀 1 4 ☐ Donation 5		3 Removal from	III State			ther place	e)	1-1	10-05			
Бащтог	nit. F artme ortar injur e.		21. Signature of Fund			Me	tropoli		d Addres	s of Facility	Q ' 1	rshall's	lexa	indria,	VA.
Ď	Deparming Department Important Irreportant		DOP	ma	shall	,	42	17 91	h. 9	St N	TJ T	Vashingt	run	neral H	ome
			23a. Parti. Enter the	disease, or	complications tha	t caused the dea	ath. Do not ent	er the mod	e of dying	g, such ats	cardiac o	r respiratory arre	est,	D.C. 2	Approximate
ş. I	Physician		Immediate Cause (F	allure. List	only one cause or	each Me.		"		1	0				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		a. Due t	to for as a donse	quence of):	ry	, ui	un	۶.	7			
	Examiner		Commentally lies and	iat	. (	ours	intu.	6/4	lair	La	Hu.	18			
-	D ==	ner	Sequentially list cond dany, leading to inni- cause. Enter Underly Cause (Disease or in	odiate	Due t	o (or as all onse	quence of):			1					
	scute ind trans	Examiner	Cause (Disease or in that initiated events resulting in death) La		с									1	
Š,	oe executan a	ŭ	resulting in death) La	51	Due t	o (or as a conse	quence of):								
0/0	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical			d										
2 X	that the death certific ed by the attending p detached for use as	/Me	IF FEMALE:		230 If yes 6	uitaama af araas	2000								
ם	atten for us	ian	23b. Was decedent p in the past 12 m	onths?	1 Live	outcome of pregre birth 2 Pet gnant at time of	al death 3	Ectopic pr					23	<li>d. Date of delike Month</li>	/ery Day Year
5	the d	Physician/Me	1 ☐ Yes 2 ☐ I 9 ☐ Unknown	No	9□ Unl		death 5	Other (sp	өспу)						,
Ĺ	that the ed by detail		Part II. Dther signific	ant conditio	ns contributing to	death but not re	sulting in the u	nderlying c	ause give	n in Part I.		23e. Did tob	acco use	contribute to	the cause of death?
colus,	uires that signed to lid be deti	d by										1 ☐ Ye	s 2 🗆	No 3□Pro	bably 43 Unknown
5	w require	Completed										24a. Was ar	, 1	24h Wara aut	opsy findings available
ב י	he la e has age 2	dmc				<u></u>					-	autops	red?	prior to co death?	ompletion of cause of
		o O	25. Was case referred	to medical						GE Place	of Dogsth	1 ☐ Yes 2	Mo No	1 🗆 Yes	2□No
5 :	ysici s cer direct	0.0	examiner?		Hospital:	XInpatient 2□	] ER/Outpatien	it 3 DO	A Othe	r.		ne 5 Reside		Other (Speci	(6.1)
5 7	g Physie this seral di	L :	27. Manner of Death		28a. Dat	e of Injury onth, Day Year)	28b. Time of		8c. Injury Work			28d. Describe ho			197
5	death. stor: After / the funer	atio	<ol> <li>Natural</li> <li>Accident</li> </ol>	5 Pending investig	ation	min, Day (Gai)	Injury	М		res 2□N	lo				
2 :	r Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could n determi	288. Pla	ce of Injury - At I	nome, farm, str	eet, factory	, office		2	8f. Location (Str City or Town	eet and I	Number or Rur	al Route Number,
ָ ב	ital o	Cer			,										
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	ical	29a. Certifier 1 (Check only 2	X Certityind ☐ Medical E	Physicien: To the exeminer: On the and ma	he best of my kn basis of examin	owledge, death ation and/or inv	occurred :	at the time	e, date and	place, a	and due to the ca	use(s) ar	nd manner as s	stated.
:	thin 2 the mplet	Medical	one) 29b. Signature and tit	//	and ma	anner stated.	/		License						
1	Z × Z 8			2 Total	11 1	1 th		290	LL	TUTTOOT	~	29		signed (Month,	uay, rear/
		<b>y</b>	20 Non-	36	m	10	- 00 \ -		/ )	10	5		6-4	<del>-</del> 05	
1	11		30. Name and addres	Smith.	MD. 760				'akom	a Par	k. M	fd. 2091	2		
ř	Sta	te	31. Date filet (Month,	Day, Year)		Registrar's Sign				LUL	~~ 5 F.	2071			
	Registr	1.5	J	JN 0 7	2005	source of	IS PA								

			1 - For State Registrar	State of M	laryland / Dep		Health ar	nd Mental Hyg	3	18973
Н	Physici	an	1. Decedent's Name (First, Middle,	•	_	1		2. Date of Dea Month	Day Ye	3. Time of Death
	/Medio	cal	Catherine	Т.		ewczak		June 2	7	22:43 P <sup>M</sup>
	Examir	ier	4a. Facility Name (If not institution, Mercy Hospital  5. Social Security Number		ge (In yrs. last birthday	Balti			4c. County of [N/	A
	Funeral Director		218–03–3525 Usual Residence of Decedent	1 □ M 2 🔏 F	92 Yrs.	Months Day		Min. 8. Date of Birth (Month, Day September	22 <b>,</b> 1912	Birthplace (State or Foreign Country) MD.
	anylan show	-	10a. State 10b. County N/A		10c. City, Town or L	ocation ore City	7			10d. Inside City Limits 1 Yes 2 □ No
	the N	ect	10e. Street and Number		Darein	10f. Zip Code			Og. Citizen of Wha	
	3a or	io I	634 South Potoma	ac Street		212		1	USA	Country
36	be filed within 72 hours after death with the Maryland tall Hygiene. Id other then "natural", or items 23a or 28a-f show of other then "natural", or items 23a or 28a-f show event, the Medical Exam har must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Marrie  3 🛣 Widowed 4 Divorced	If Yes, Give	? [No	Was Decedent of If Yes, specify C		n? (Specify Yes or No- Puerto Rican, etc.)		American Indian, Vhite, etc. White
9	2 hour	ted b	15. Decedent's	Year or Dates:	16a. Dec	edent's Usual Occ	cupation		16b. Kind of Busin	
21215-0036	filed within 7 Hygiene. nther then "n ant, the Med	Completed	(Specify only highest Elementary/Secondary (0-12) 3 years	College (1-4or	5+) life.	e kind of work doi DO NOT use ret usewife	ne during most o ired)	f working	Own Home	
Maryland	ould be filed Mental Hygi arkad other latic event, I	Be	17. Father's Name (First, Middle, La	ast)				Name (First, Middle, I	Maiden Sumame)	
2	d 2 should be th and Menta the marked treumatic ev	은	Peter Helowicz  19a. Informant's Name/Relationshi	o (Type, Print)	19b Mail	ing Address (Stre		Bogdan  or Rural Route Number	City or Town Sta	te Zin Code)
	nd 2 still ar ar 27 is r treu		Joseph Lewczak	son				Dundalk, MI		le, <i>Elp</i> Code)
Baltimore,	Pages 1 and nent of Healt ent: If Item 2' ary or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spe	3 □Removal from State	20b. Place of Disp cemetery, cre St. Stanis			ne 6, 2005 I	20c.Location-City Baltimore	
Balt	permit. Pag Department Importent: i any injury o once.		21. Signature of Funefal Service Li	censee	Elen 3	2 Name and Add Connelly 7110 Sol	Funera. Lers Po	l Home Of D int Road, D	Dundalk, 1 Dundalk,M	P.A. D. 21222
	rnysician /Medical Examiner		23a. Párt1. Enter the disease, br c shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a	s a consequence of):	H	tying, such as ca	rdiac or respiratory arr	est,	Approximate Interval Between Onset and Death
8760,	ate be executed obysician and the burial-transit	Ical Examiner	ir any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. ASC	s a consequence of):					
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yo 9 ☐ Unknown		2 Fetal death 3	□Ectopic pregnai □ Other (specify)			23d. Date of Month	delivery Day Year
	quires that in signed b uld be deta	by	Part II. Other significant condition		but not resulting in the	underlying cause	given in Part I.	23e. Did tot	1	e to the cause of death?  Probably 4 Unknown
Vital Records,		Completed						24a. Was a autops perform	y prior	
Vita	Physicien: 'this certificaral director, p	Be	25. Was case referred to medical examiner?	Hospital:	n. 19			Death Check onl on	8	
Ö	Phys this al diu	. To	1 ☐ Yes 2 No 27. Manner of Death	1 _ Inpati		of 28c In	4 ☐ Nursi	ng Home 5 Reside	ence 6 Other (5	Specify)
lo	Attending F r death. ector: After by the funer	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Inj (Month, Date)	ay Year) Injury	W	√ork? □Yes 2□No		w injury occurred	
É	i Siri G	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28f. Location (St. City or Town		r Rural Route Number,				
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physicien: To the besi caminer: On the basis of and manner s	of examination and/or is	th occurred at the	time, date and p y opinion, death	place, and due to the ca occurred at the time, da	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
	Tot Tot com	Σ	29b. Signature and title of contifier	- w)		1	2427		9d. Date signed (M	
	10		30. Name an dress of person w	ho completed cause of	death (Item 23a) (Type	Print)	muz	W	2122	~
	Sta Registr MH 17 Rev 1/2	ar	31. Date filed (Month, Day, Year)	7 2005	rar's Signature	books			7177.0	

ORIGINAL

Carl Lindblad 05-03771 NJM

–037 M	/1		State of Maryland / Department of Health and M 1- State Unpend Item 23a, pt.II, 27, 28a-f. per me G844 6-16-05 Certificate of Death	lental Hyg 5 tas	giene	5 18971
	Physic /Medi		1. Decedent's Name (First, Middle, Last)  LARL OAVIO LINOBLAO	2. Date of Dea Month June	ath	3. Time of Death 05 1725 M
8	Examir	ner	4a. Facility Name (If not institution, give street and number)  901 Philadelphia Road  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year  If Under 1 Year  If Under 24 Hrs.	0. Data at 0.11	4c. County of Harfor	d
22	Funeral Director		Usual Residence of Decedent	8. Date of Birth (Month, Day	(Year)	Birthplace (State or Foreign Country)
	ith the Marylar or 28a-f show a notified at	Director	10a. State 10b. County 10c. City, Town or Location 10c. City, Town or Location 901 PHILAOSLAHIA ROAD -			10d. Inside City Limits 1 ☐ Yes 2 No
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23a or 28a-1 show other treumetic event. If a Marylad Exarciner must be notified at	Funeral Dir	10e. Street and Number  10f. Zip Code  10f. Zip Code  10f. Zip Code  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Version Code)  14. Was Decedent of Hispanic Origin? (Specific Version Code)		10g. Citizen of Wha	American Indian,
5-0036	72 hours after death w "naturel", or items 23a	b	1 □ Never Married 2 Married 1 1 O Yes 2 □ No If Yes, Give Vear or Dates:	Rican, etc.)	Specify:	white, etc.
21215-	filed within 72 hours after Hygiene. other then "naturel", or ite ent. If e Machel Examiltie	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  ATRS  16a. Decedent's Usual Occupation (Give kind of work dane during most of working life. DO NOT use retired)  SILT EMPLOYS	ng	16b. Kind of Busin	•
Maryland 2	12 should be filed w h and Mental Hygier 7 is marked other ti reumetic event, IL.	To Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name  HARRY LINGSLAD  008077	M KA	Maiden Sumame)	MARONIMENT
	ges 1 and 2 sho t of Health and I if item 27 is ma or other treume		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Tura)	I Route Number	r, City or Town, Sta	te, Zip Code) 2/050 NARYLAND
Baltimore,	Page nent o ant: If ury or		1 Burial 2 Cremation 3 Removal from State  Language Company Crematory or other place)  Language Company Crematory or other place)	4, 20 S	20c. Location - City	IL MARYLAND
Ba	permit. Departr Importe eny inji		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or	FOREST!	HIT WAS	ALANO Approximate
	Pnysician /Medical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Intracranial Hemorrhage  Due to (or as a consequence of):			Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (orsease or injury)			
8760,	ate be executed hysician and the burial-transit	cal Examine	that initiated events resulting in death) Last  C. Due to (or as a consequence of):  d			
P.O. Box 68	s that the death certifical ned by the attending ph. s detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of Month	f delivery Day Year
ords, P	w requires that been signed t should be deta	by	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.  Chronic Alcohol Abuse			te to the cause of death?  Probably 4 DUnknown
of Vital Records,	: The law r cate has be , page 2 sh	Completed		24a. Was ar autops perform 1 Yes 2	y prior	e autopsy findings available to completion of cause of h? Yes 2 \sumbox No
sion of Vita	or Attending Physicien: The law requires that the death certificater death. Directed After this certificate has been signed by the attending p in by the funeral director, page 2 should be detached for use as	ertification; To Be	27. Manner of Death  1 Natural 5 Pending investigation  28a. Date of Injury  Found  28b. Time of Work?  Found  28b. Time of Nury  Found  1 Yes 2 No	ne 5 Reside	e) ence 6 <b>X</b> Other (5 ow injury occurred	Specify) Scene unk
Division	spitel or Atte ours after de terel Directo filled in by th	O	3 Suicide 4 Homicide  Could not be determined  288. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  Scene	Joppa, r	DP	hiladelphia Rd
	the Hos nin 24 h the Fur npletely	Medical	29a. Certifier (Check only one)  1☐ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, are checked only one)  2★Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d at the time, da	ate and place, and	due to the cause(s)
	with		Pamate Bouthall, MI OCME		June, 2,	
		-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Pumelic E. Southall, MD 111 Penn Street  31. Date filed (Month, Day, Year) 32. Repear's Signature	Baltimo	ore, Mary	land 21201
	Sta Registra	.e	JAN 6 7 2005			

			For Sta	te of Maryland / Depa	artment of H	lealth and Me	_	_	10075
			State Ragistrar	Cei	rtificate of l			. No. U U D	18919
	Physici	an	Decedent's Name (First, Middle, Last)			2	. Date of Death Month	Day Year	3. Time of Death
	/Medic		Howard Leon Lough				May 20,	2005	4:00 PM
	Examin	er	4a. Facility Name (If not institution, give street a			Location of Death		4c. County of Death	
			Casey House Hospice  5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Rockville If Under 1 Year		. Date of Birth	Montgomery	
	Funeral Director		1₽ M 2	JE Vm	Months Days	Hours Min.	(Month, Day, Y 4=27-191	(ear) Cou	place (State or Foreign ntry) (lin, WV
			232 26 7596 X 25 Usual Residence of Decedent	91 715.			<del>1</del> 2/-131	4 FLain	CTTII/ WV
	yland		10a. State 10b. County District of	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mar 9-1-8	tor	DC Columbia	Washingto	n				1√ Yes 2 No
	or 28	by Funeral Director	10e. Street and Number US Soldiers & Airmans	s Home	10f. Zip Code		10g	. Citizen of What Cou	ntry?
	23a	lai	3700 North Capitol St	., NW	20317			ited State	
	tems	nue	Am	s Decedent Ever in U.S. 13. \ led Forces?	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Speci In, Mexican, Puerto Ri	ty Yes or No- can, etc.)	14. Race - Ameri Black, White	
36	s afte	Ϋ́	1 Never Married 2 Married 1 X If Y A Widowed 4 Divorced Year	Yes 2 □ No es, Give ar or Dates:	1 ☐ Yes 2 ☒ No	Specify:		Specify: Whit	ce
٥ ٻ	filed within 72 hours after death with the Maryland Hygiene ther than "netural", or Items 23a or 28e-f show ther than Bedieal Examinat must be notified at		15. Decedent's Education	16a, Deced	dent's Usual Occupa	ation	16	b. Kind of Business/Ir	
15	n "ne	Completed	(Specify only highest grade comp	lege (1-4or 5+) (Give life. I	kind of work done of DO NOT use retired	during most of working ()			
212	d with	E	12		litary		U	S Military	7
פ	e file al Hyc othe vant,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name (	First, Middle, Ma	iden Sumame)	
<u>a</u>	Venta Wenta wrked	2	Howard Lough			Hattie D.	Glover	Lough	
Maryland 21215-0036	sho and I		19a. Informant's Name/Relationship (Type, Prin			and Number or Rural F		City or Town, State, Zi	p Code)
≥,	and ealth m 27	1 8	Richard Lough			nklin, WV	26807	a Lacation City of T	inum Stata
Ore	ges 1 t of H ital		20a. Method of Disposition  ↑ Burial 2 □ Cremation 3 □ Remova  ↑ 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo cemetery, crer		ee)		c. Location - City or T	
Ē	tmen tant:					-	)5 Fr	anklin, W	J
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "notural; or items 23a or 28e-1 show amy injury or other traumatic avant, the Medical Examinal must be notified at ance.	j, j	21. Since re of Funeral Service Censee	В		neral Home			
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death. Do not ent	OB 215 - ter the mode of dyin	Franklin,	WV 268 respiratory arrest	07 <del>-</del> 0 <del>2</del> 15	Approximate
490									Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Carcinoma of unk	TIOMII DETI	liary		-	Months
	Examiner			de to (or as a consequence or).					
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ue to (or as a consequence of):					
	uted id anslt	Examiner	that initiated events c						
oʻ	te be executed ysician and ne burial-transit		resulting in death) Last	due to (or as a consequence of):					
3760,	ate be hysici the bu	lical	d						
68 0	certifical rding physe as th	Mec	IF FEMALE:	and a stranger of programmy					
Вох	death certificate I ie attending physi ed for use as the t	ian/	23b. was decedent pregnant		Ectopic pregnancy Other (specify)	•		23d. Date of delive Month	ery Day Year
<u>o</u> .	0 0 0	Physician/Medi		Unknown					
٥.	requires that the de been signed by the hould be detached		Part II. Other significant conditions contributing	ng to death but not resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ds,	uires tha signed Id be del	d by					1 ☐ Yes	2 No 3 □ Pro	bably 4 🗆 Unknown
COL		ompleted		**			24a. Was an	24b. Were aut	opsy findings available
Re	The law ate has b page 2 st	ф					autopsy performe	d? death?	ompletion of cause of
Vital Records	ician: Th certificate rector, pag	C	25. Was case referred to medical		:	26. Place of Death (	·	2140	20.110
>	di s	O B	examiner? 1 ☐ Yes 2√ No Hospita	1 Inpatient 2 ER/Outpatier	nt 3 DOA Oth	er: 4 🗆 Nursing Home	5 🗆 Residend	ce 6 Nother (Speci	h)Hospice
J Of	ding Phys h. After this funeral di	n: T	27. Manner of Death  1 Natural 5 Pending	Date of Injury 28b. Time of (Month, Day Year)	f 28c. Injun Wor	v at 28	d. Describe how		House
ior	Attending ir death. actor: After by the fune	atlo	2 Accident investigation		M 1 🗆	Yes 2 □ No			
Division	l or Attence after death Diractor: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e	<ul> <li>Place of Injury - At home, farm, str building, etc. (Specify)</li> </ul>	reet, factory, office	28	f. Location (Stre City or Town, 3	et and Number or Rur State)	al Route Number,
Ω	ital o						4 4 - 4 - 4 - 4		
	To the Hospital or Attenswithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Examiner: Or	To the best of my knowledge, death the basis of examination and/or in dimanner stated.	h occurred at the tin vestigation, in my o	ne, date and place, an pinion, death occurred	d due to the cau. Lat the time, date	se(s) and manner as a and place, and due to	stated. to the cause(s)
	thin 2 thin 2 or tha	Mec	29b. Signature and title of certifier	d mainer stated.	29c. Licens	e number	29d	. Date signed (Month,	Day, Year)
	F ≱ F 8		De Colorita las.	$\mathcal{V}$	RRUT	16114	M	lay 21, 2	2005
	3		30. Name and address of person who complete	od cause of death (Item 23a) (Type,	Print)	7 0 11 7		,	
	Ü		Chitra Rajagopal + Co	sey House Hosoi	ce - 6001	Muncasterl	Yin Rd K	POCKVIlle M	020855
	Sta	ate	31. Date filed (Month, Day Year)	32. Registrar's Signature			)		
	Regist	rar	JUN 0 7 2005	od cause of death (Item 23a) (Type.  25 cy HOUSe H650)  32. Registrar's Signature					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 2005 JUNE CECIL GIBSON LOCKE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE BLAKEHURST HEALTH CENTER TOWSON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/9/1916 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 😿 F Months MARYLAND 88 218-14-8655 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No BALTIMORE TOWSON Funeral Director MD 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number ŏ 21204 USA 1055 WEST JOPPA RD 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. or items 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: altimore, Maryland 21215-0036 Specify: ģ WHITE 3 Widowed 4 ☐ Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) other than HOMEMAKER HOUSEWIFE 12YRS Pages 1 and 2 should be filed v thent of Health and Mental Hygie trant: if Item 27 is marked other t jury or other traumatic event, ID 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ELEANOR JOHNSTON EDWARD GUEST GIBSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 7806 MAPLE AVE TOWSON, MD. 21204. ROBERT W. LOCKE(SON) permit. Pages 1 and Department of Healt Important: if item 2 any injury or other 000.08. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ST. THOMAS CEM. 06/11/2005 OWINGSMILLS, MD. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee HENRY W. JENKINS & SONS CO 16924 YORK RD MONKTON, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Heart argestive Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician Box 68760 Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 menths?

1 Yes 2 No
9 Unknown 5 Other (specify) detached P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate has 1 ☐ Yes 2 ☐ No 2/2/No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 📈 o 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Gedelli Jakhrt II H.D. D334-00 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOIN CHALLES ST BALTIMORE, MD IGLIGHART III MO 31. Date filed (Month, Day, Year) 32. Registrar's agnature State Registrar

State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2005 A M June 5:50 Robert J. Lavell /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Montgomery 9909 Logan Drive Potomac | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 4, 1922 Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 83 1⊠M 2□F Yrs. 0hio Director 283-12-4978 Usual Residence of Decedent 72 hours after death with the Marylend 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County d 2 should be filed within 72 hours after death with the Marylen th and Mental Hyglene. 27 is marked other than "natural", or Items 23a or 28a-f show treumatic event, the Madical Expt. Inst.; unt be notified at 1 ☐ Yes 2 No Director Maryland Potomac Montgomery 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number 20854 United States 9909 Logan Drive Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 X Yes 2 No If Yes, Give WWII Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Economist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Edna Hezzisheimer Robert James Lavell . Pages 1 and 2 should by Iment of Health and Mentatent: If Item 27 is marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9909 Logan Drive, Potomac, Maryland 20854 Mary U. Lavell/ Wife other t 20b. Place of Disposition (Name of compter, cremators or other place)
St. Gabriel's
Cemetery June 7, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ō permit. Page Department of Importent: If any injury or Potomac, Maryland 2005 \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Monteomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee ⊃ мо1386 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line., Approximate Interval Between Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9 Unknown r signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has 1 ☐ Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 esidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No his funeral ( 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. the To the Hospitel or Attend within 24 hours after death To the Funerel Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and little of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GROVE RD RICKYLLE MD 20850 15225 1-CHANAUS 32. Registrar's Signature 31. Date filed (Month, Day, Year) JUN 0 7 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decement's Name (First Middle Last) 2. Date of Death Month Year **Physician** 200 /Medical Facility Name (If, not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bathmore

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day,
Hours Min. (Month, Day, Wary SUSEM 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Months 1 M 2 M F 218-92-5282 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "netural", or items 23a or 28e-f show any injury or other traumatic event. If a Medical Exercities Traist by Inclined at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 1610 Ruxton Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1,4or 5+) Domestic 12tharade Homemaker NI 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willie Talley Fannie Mae ပ 19a. Informant's Name/Relationship (Type,, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Husband Paul W. Marable Road Baltimore MD 21216 1610 Ruxton 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 06.07.05 Baltimore MD \* 4 ☐ Donation 5 ☐ Other (Specify) Arbutus 21. Signature of Funeral Service Licensee 22, Name and Address of Facility
VAUCHN C. GREENE FUNTRY SERVICES
SIST BUTTOMPE NOTIONAL PIKE BUTTO. MUZIZZY 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stage Physician /Medical Que to (or as a consequence of): Examiner batitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit Hospital or Attanding Physician: The law requires that the death certiticate be executed the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month Dav Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ate has been signed by i page 2 should be detach Part II. Other significant conditions contributing to death but not resulting if the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No autopsy performed? this certificate 2 No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 1 i Impatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending s after dea. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours a To the Funaral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Monuta 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2120

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			1 - State o	f Maryland		artment of I tificate of		d Mental Hyg	giene	)5	18979
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  CATHERINE	٨	11 11	5		2. Date of Dea Month	Day	Year 200 5	3. Time of Death
	Examin		- ( ) ( ) ( )	-THWES			or Location of D	TIME	BA	ty of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ▼ F	7. Age (In yrs. las	Yrs.	Months Days		Hrs. 8. Date of Birth (Month, Day JUN 2,	1925	of Co	lace (State or Foreign try)DISTICT Dlumbia
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation				10	0d. Inside City Limits
	Maryl-f sho	tor	Maryland N/A		Ι	Baltimore	9				1 XYes 2 ☐ No
	th the or 28a e routi	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?
	23a c		5801 Bland Avenue			2.	1215			USA	
036	be filed within 72 hours after death with the Maryland ital Hygiene. od other then "natural", or Items 23a or 28a-f show event, it a Medicul Evand or must be rediffed at event, it a Medicul Evand or must be rediffed at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Deccarded 1 Yes, Ging Year or D	2 (XNo ve		Vas Decedent of I f Yes, specify Cub □ Yes 2∑XNo		? (Specify Yes or No- uerto Rican, etc.)	14. Ra Bla Speci	ice - America ack, White, e ify: B1	
Baltimore, Maryland 21215-0036	within 72 ho ane. Ihan "natur a Medicul	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1	1-4or 5+)	(Give life. L	lent's Usual Occu kind of work done DO NOT use retire	during most of ad)	working	16b. Kind of E		•
<b>d</b> 2	filed Hygie other ent, to		17. Father's Name (First, Middle, Last)		Regi	stered I		Name (First, Middle,		spital me)	
ılan	uld be Jental rked tic ev	To Be	Freeman Jackson				Rutl	n Smith			
, Mary	ges 1 and 2 should be filled within it of Health and Mental Hygiene. If item 27 Is marked other than " or other traumetic event, if a Mer.		19a. Informant's Name/Relationship ( <i>Type, Print</i> ) Mia Minion/daughter			g Address <i>(Str</i> ee Claybro		r Rural Route Number Ve Windso			,
imore	permit. Pages 1 and 2 Department of Health s Importent: If item 27 Is any injury or other tra		20a. Method of Disposition  1  Burial 2 XCremation 3 Removal from  4 Donation 5 Other (Specify)	State cen	netery, cren	sition (Name of natory or other pla ematory,	- 1		20c. Location Baltir	-	
Balt	permit. Departr Importe any inj		21. Signature of Funeral Service Ucensee Community Description F. McDonald	rald				ty of Mary oad Balti			228
			23a. Part1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e	aused the death. each line.				diac or respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to	(or as a conseque	+ - ' '	P tto M	4				
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	(or as a conseque	nce of):						
	cuted Id ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	(							
8760,	icate be executed physician and s the burial-transit			(or as a conseque	nce of):						
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.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months?	come of pregnand birth 2 Tetal d nant at time of dea own	eath 3	Ectopic pregnand Other (specify)	у			ate of deliver onth	ry Day Year
<u> </u>	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to de	eath but not result	ing in the ur	derlying cause gr	ven in Part f.		bacco use con es 2 □ No	stribute to the	e cause of death?
Il Records,		Completed						24a. Was a autops perform	in 24b. sy med? 217No	Were autop prior to com death? 1 \( \text{Yes} \)	osy findings available apletion of cause of
Vital	sicien; Th certificate rector, pag	Be	25. Was case referred to medical examiner?  1 Vec. 3 Parts Hospital:					Death (Check only or			
o	g Phys er this eral dii	n: To	27. Manner of D ath 28a. Date	of Injury 2	NOutpatien 8b. Time of	28c. Inju	ry at	g Home 5 Reside			)
sion	ending sath. or: Aft he fun	atlo	2 Accident investigation	th, Day Year)	Injury	M 1 [	rk? ]Yes 2 □No				
Division of	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	4 Homicide documents buildi	of Injury - At hom ng, etc. (Specify)				28f. Location (Si City or Town	n, State)		
	he Hosp in 24 hou he Funei pletely fil	edical	29a. Certifier (Creck only one) Certifying Physician: To the part of the control one) Certifying Physician: To the care of the control one of the	best of my knowle asis of examination ner stated.	edge, death n and/or inv	occurred at the ti restigation, in my	me, date and pla opinion, death o	ace, and due to the cocurred at the time, d	ause(s) and m ate and place,	anner as sta and due to	ited. the cause(s)
-	To t Com	Σ	29b. Signature and title of certifier	ly		29c. Licens	se number	333 2 MDZ11	9d. Date signe	S 2	DoJ
2	0		30. Name and address of person who completed cause	MD	NHO	Print) A	LTO.	MPZII	33	7	
	Sta Registr		31. Date filed (Month, Day, Year)  JUN 0 7 2005	egistra s Signatui	i, J.	Aparti	7				

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician May 31,2005 Year 10:40am M John No1an Maddox /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Shady Grove Adventist Hospital Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Jan. 15, 1930 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 437-42-4219 1**⊠**M 2□F 75 Yrs. Haynesville, LA Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or items 23e or 28a-1 show any injury or other treumetic event, the Modified Examination ust be notified an once. MD Montgomery Gaithersburg Director 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20877 301 Russell Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married White altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Atomic Energy Elementary/Secondary (0-12) College (1-4or 5+) Industrial Chemist 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Audis Maddox Carmen E. Goodwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2500 Waterside Drive Unit 401, Frederick MD21701 John Rezash 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State June 4, 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State Maryville, TN Grandview Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 East Fort Ave Baltimore MD 21230 2 2L. P. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Sepsis Days /Medical Due to (or as a consequence of): Examiner Pneumonia Davs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) Examiner that the death certificate be executed that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): attending physician Physiclan/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy been signed by the attershould be detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 autopsy performed? certificate 1 ☐ Yes 2 X No 1 ☐ Yes 2 No of Vital 25. Was case referred to medical examiner? Be director 26. Place of Death (Check only one) 1 ☐ Yes 2 🛣 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this the funeral 27. Manner of Death 28c. Injury at Work? Date of Injury (Month, Day Year) 28d. Describe how injury occurred After t Division To the Hospitel or Attending 5 Pending investigation 1 Natural after death. Director: A 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00057954 JUNE OI, ZOOS 20 ROLLVILLE ess of person who completed cause of death (Item 23a) (Type, Print) YARZ ADEUNIT HOSPITAL MO WD 2085D JOHN SNADA CROFE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 7 2005 Registrar

Sadie Mack 05-03656 crn

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State Registrar			rtment of H tificate of L		R	eg. No.	UJ	19991
Physic	ian	Decedent's Name (First, Middle, Last)	•				2. Date of Dear Month	Day 27	Year	3. Time of Death
/Medi			Sadie	маск			May		2005	11:00 A M
Exami	iner	4a. Facility Name (If not institution, give s 1635 N. Gilmor Str			4b. City, Town, or Baltin				nty of Death	
Fireces		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day			lace (State or Foreign
Funeral Director			M 34□F 71	Yrs.	Months Days	Hours Min.	Jul 8,	Year) 1933	Cour	lace (State or Foreign stry) S. C.
P		Usual Residence of Decedent								Od to id- Challenia
arylar show	_	10a. State 10b. County		y, Town or Lo		ltimore				0d. Inside City Limits 1 Yes 2 □ No
he M	Director	Maryland N/A			10f. Zip Code			On Citizen	of What Cour	
with t	ρ	1635 North Gilmore Street			Tot. Zip Code	21217	'	og. Onizen	U.S.A	•
72 hours after death with the Maryland reatural; or Items 23s or 28s-1 show dies Evantred to rediffed at	by Funeral		2. Was Decedent Ever in U	.S. 13. V	Vas Decedent of Hi	spanic Origin? (S	pecify Yes or No-		Race - Americ	
after or Iter	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	1	Yes, specify Cuba	n, Mexican, Puero	o Rican, etc.)		Black, White,	
ral', c	1 by	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		Yes 2 🛭 No	Specify:		Spe	cify:	lack
72 h	Completed	15. Decedent's Educ (Specify only highest grade		(Give	lent's Usual Occupa kind of work done of	luring most of wor	king	16b. Kind o	f Business/Inc	dustry
within	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	III e. L	OO NOT use retired <b>Nurs</b>	e's Aide		Nor	th Charle	s Hospital
filed Hygie ther		17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Sun	name)	
id be ental ked c eve	To Be	Henry	Lunn				Eva	Rosa Lu	nn	
d 2 should be filed within 72 hours aft than Amerial Hygiene. 27 is marked other than "natural", or treumatic event, if a Modical Enam	-	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailin	g Address (Street a	and Number or Ru	ral Route Number	, City or To	wn, State, Zip	Code)
and 2 alth a		Roy Mack Son		31	Tallow Court	Randallstov	vn, Md. 2124	4		
of He of He f Item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R		Place of Dispo cemetery, cren	sition (Name of natory or other plac	θ)	Date		on - City or To	
Pag ment ent:		`4 ☐ Donation 5 ☐ Other (Specify)		King	Memorial Pa	irk	06/04/05	W	indsor Mi	lls, Md.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23s or 28a-1 show any Injury or other treumstic event, Ite Medical Eraninet must be notified at once.		21. Signature of Funeral Service License	File	22	. Name and Addres Estep Bi	others Fune	ral Service P	A 21217		
		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the deat	h. Do not ent			altimore, Md or respiratory arr		1/3	Approximate Interval Between
Physician	L.	Immediate Cause (Final	e cause on each line.	W. C.						Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as conse	uence of):					-	
Examiner		O to seal to the that are distance								
D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs Diseases or injury	Due to (or as a consec	quence of):						
ecute and trans	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	uanaa af):						
ificate be executed g physician and as the burial-transit	al E		Due to (or as a consec	(uerice or).					Political and the control of the con	
	dical		l							
	lan/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn		-			23d.	Date of delive	ery
death cer attendin d for use	O	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		]Ectopic pregnancy ] Other (s <i>pecify)</i>				Month	Day Year
at the de by the	Physi	9 Unknown	9LJ Unknown							
requires that the	by P	Part II. Other significant conditions cor	tributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.		W		he cause of death?
w require been si should I							1 🗆 Y	es 2LALN	o 3 Prot	pably 4 □Unknown
law as b	ompieted						24a. Was a autop:	Sy	prior to co	psy findings available mpletion of cause of
# G	Con						1 XYes	2□ No	death? 1 D Yes	2 🗆 No
Physicien: T this certificate al director, pa	Be	25. Was case referred to medical examiner?	lospital:		Oth		ath (Check only or			
this ald	P.	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatier 28b. Time of	it 3 DOA	4   Nursing F	lome 5 Resid			yat scene
	tion	1 Natural 5 Pending 2 Accident investigation	Found Day Year)	Tound	Wor	k? Yes 2∭ No	Suhi	ect 0	essau	ited
I or Attending after death. Director: After I in by the fune	ifica	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, str	eet, factory, office		28f Location (S	treet and Ni	ımber or Rum	al Route Number
- 5 th to	Certification:	4 Homicide	building, etc. (Speci				5+. B	il tiv	WOVE	Gilmare
Hospital of 24 hours at the Funeral Dietely filled it	edical (	29a. Certifier 1 Certifying Phy (Check only	sician: To the best of my kn ner: On the basis of examina	owledge, deat ation and/or in	n occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	e, and due to the curred at the time, o	ause(s) and late and pla	manner as s ce, and due to	tated. the cause(s)
To the Hos within 24 h To the Fun completely	Med	29b. Signature and title of certifier	GROTING STOR STOREGO		29c. Licens	e number	2	9d. Date si	gned (Month,	Day, Year)
F3F8		land H	9 0 001 10 11	id	OCN	Œ		May 2	8, 200	15
		i cautil	went n	- 02-) (Tues				_ Luly 2	.5, 200	1000
12	1	30. Name and address of person who co	impleted cause of death litte	m 23a) (1ype.	Pnnt)					
13		30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type,		n Street	Baltin	ore,	Maryla	nd 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** NOG June /Medical 4c. County of Death Facility Name If not institution, give street and number) Examiner Bune 8. Date of Birth Month, Day, Year Sept 5, 1942 Birthplace (State or Foreign Country) If I Inde fear If Under 24 Hrs. . Age (In yrs. last birthday) **Funeral** Days Hours Months 1 ☐ M 2 🗹 F 214-40-1861 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits or 28a-f show if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, It a Madical Examinar must be natified at 1 ☐¥Yes 2 ☐ No Baltimore N/A Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21230 1528 Byrd Street USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after in nent of Health and Mental Hygiene. sort: If item 27 is marked other than "natural", or Ite 1 ☐ Yes 2 🕅 No 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teller 0 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Kathryn Grace Redolf Thomas Alonza Metzger, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) David M. McGee, Sr. (Husband) 1528 Byrd St., Baltimore, Md. 21230 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Crematory, Inc. 6/6/05 20a. Method of Disposition 20c. Location - City or Town, State pernit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
130 E. Fort Ave., Balto., Md. 21230 21. Signature of Fundal Service Licensee Kevin E Ecker 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Completed by Physician/Medical Examiner sician and burial-transit that initiated events resulting in death) Last attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 1 Live birth 2 ☐ Fetal death Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ Yo 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Viena 0 1 Yes 2 Deans 3 Probably 4 Unknown Doep Verious Thinks Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? extremity 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Appatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes No 7 27. Manner of ath 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be

The law requires that the death certificate be executed Box 68760. P.O. Records, Division of Vital To the Hospital or Attending Physician:

21215-0036

Baltimore, Maryland

within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral

3 Suicide

29a, Certifier

Medical

State

4 T Homicide

29b. Signature and title of certifier

determined

31. Date filed (Month, Day, Year) 2005

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			For State Registrar	State of I	Maryland		artment <i>tificate</i>					Reg. No.	005	189	83
	Physicia	ın	1. Decedent's Name (First, Middle,							2	2. Date of De Month	Day			of Death
	/Medic	ai	Marjean Mase  4a. Facility Name (If not institution, g	mare and aumh	arl		4b. City, 7	Four or I	ocation		lune	2	2005 County of Dea	6:17	P M
	Examin	er	3108 Rices Lane	ive street and numb	51)			imor		Deau			ltimor		
	Funeral				Age (In yrs. la	ist birthday)	If Under		If Under 2 Hours	24 Hrs. 8	B. Date of Bir	th	9. Bir	thplace (State ountry)	or Foreign
п	Director		491-24-6199	1 □ M 2 🖾 F	79	Yrs.	MOTILIS	Days	Tiours	IVIIII.	Jan 15	, 192	26 Mis	souri	
	and	-	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside	City Limits
	Marylan -f show fied at	to	Maryland Baltim	ore	Bal	timore	2							1 □ Yé	s 2X No
	h the	Directo	10e. Street and Number				10f. Zip	Code				10g. Citiz	zen of What C	ountry?	
	th wit	aiD	3108 Rices Lane				212	244					ed Sta		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural; or items 23a or 28e-f show importent: If item 27 is marked other then "netural; or items 23a or 28e-f show apprintury or other treumetic event, the Medical Ever; it ar missible notified at once.	by Funeral	11. Marital Status  1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 □ Yes 2 If Yes, Give Year or Date	as? ⊠No		Was Deced If Yes, spec 1 ☐ Yes 2		panic Orig , Mexican Specify:	gin? (Spec I, Puerto R	ify Yes or No ican, etc.)		14. Race - Ame Black, Whi Specify: V		
21215-0036	thin 72 ho e. en "netur Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4	or 5+)	(Give life.	dent's Usua kind of wor DO NOT us	k done du e retired)	ion uring most	t of working	g		nd of Business		
121	led will her the		17. Father's Name (First, Middle, La	2		Serv	ice Re	-	18 Mothe	r's Name	(First, Middle	-	P Tel	ephone	
Maryland	is 1 and 2 should be filed within of Health and Mental Hygiene. item 27 is marked other then other treumetic event, the Me	Be	lenry E. Bosch	151)				1			Holton	, maiden	Juliame		
Z	should nd Me mark mark	Ĕ	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailie	ng Address					er, City or	r Town, State,	Zip Code)	
N	alth a alth a 1.27 is		William C. Mase	more						1timo	ore, M	212	244		
ore	of He of Herr		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from Sta	20b. Pl	ace of Dispo metery, crei	sition (Nam matory or of	ne of ther place	)	Da	ate	20c. Lo	cation - City or	Town, State	
Ë	Pages tment of I tent: If it		`4 ☐ Donation 5 ☐ Other (Spe	cify)	I	raine					2005	Woo	dlawn,	MD	
Baltimore,	permit. Departr importe eny inji	1 1	21. Signature of Funeral Service Li	de la	u	B1	2. Name and urrie 212 W.	r-Oue	en F	unera	al Hom	e and infie	l Crema	tory, 21784	P.A.
			26a. Part 1. Enter the disease, or conshock, or heart failure. List or	omplications that cau nly one cause on eac	sed the death h line.	. Do not ent	ter the mode	e of dying	, such as	cardiac or	respiratory a	ırrest,		Approxim Interval B Onset an	letween d Death
10	Pnysician	ì	Immediate Cause (Final disease or condition resulting in death)	a	ung	canu	2							6 m	5-AL
	/Medical Examiner		,	Due to (or	as a consequ	ence of):									
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequ	ence of):									
	cate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease of Injury) that initiated events	c											
90	oe exe	I Ex	resulting in death) Last	Due to (or	as a consequ	ence of):									
8760,	cate b	dicai	•	d											
.O. Box 6	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ 19 9 □ Unknown		h 2∏Fetal nt at time of de	death 3	⊒Ectopic pro □ Other (sp					2	23d. Date of de Month	olivery Day	Year
ecords, P	quires that n signed b	þ	Part II. Other significant condition	s contributing to dea	th but not resu	itting in the u	inderlying ca	ause give	n in Part I.			,	se contribute t	o the cause of	
000	> 4	Completed									24a. Was		24b. Were a	utopsy linding	s available
$\alpha$	The ate h	Com										ormed?	death?	s 2 No	
Vital	Physicien: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	Hospital:				Otho			(Check only				
of	Phye this al di	. To	1 ☐ Yes 2t No 27. Manner of Death	28a. Date of		ER/Outpatie					ne 5 Res 8d. Describe		6 ☐Other (Sp	ecify)	
on	of fee	tlon	1 Aatural 5 Pending 2 Accident investiga	(Month,	Day Year)	Injury	м —	8c. Injury Work 1  Y	?" 'es 2∐i				,		
Division	Attending r death. ector: After by the fune	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 286. Place 0	f Injury - At ho , etc. (Specify		reet, factory	r, office		2	8f. Location	(Street an	d Number or F	Tural Route N	umber,
ā	tel or	Cert	4   Hornicide	Dulldary	, etc. (apechy	,					Ony 07 . 0	mi, Diato			
	To the Hospitel or Attendit within 24 hours after death.  To the Funerel Director: A completely filled in by the fu	Medical		Physician: To the b kaminer: On the bas and manne	is of examinat										Ð(S)
•	To the within to the comp	X	29b. Signature and title of certifier	liver	から			License		39		29d. Dat	te signed (Mon	th, Day, Year	)
	10	9	30. Name and address of person w		of death (Item	23a) (Type	Print)	ذول	Zt-	409	1734	altim	0/3/05	Z. a.	1093
	Sta		31. Date filed (Month, Day, Year)	2005 32	gistrar's Signa	huro									
	Regist	-30	ל א אוטגי	2005	was d										

DHMH 17 Rev 1/2001

**ORIGINAL** 

			State of Maryland / Department of Health		•	•	
			For State of Maryland / Department of Health  1- State Registrar Certificate of Death		-	eg. No. 005	18984
			Decedent's Name (First, Middle, Last)		2. Date of Dea	th	3. Time of Death
	Physicia /Medic		Nancy A. mills		Month	Z7 Zoc	0 0 1 1 1 1
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location  8288 Wood ward st.  6avacre	on of Death	,	4c. County of De	
	uneral		5. Social Securify Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 1 Under	ler 24 Hrs.	8. Date of Birth		rthplace (State or Foreign country)
	irector		365-40-3785 1□ M 2□XF 66 Yrs. Months Days Hours	s Min.	8. Date of Birth (Month, Day PUL)	0,1939 Mi	Chigan
and	<b>3</b>		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location				10d. Inside City Limits
Maryl	fed at	ō	MD Howard Savage				1⊠Yes 2□No
th the	or 28a	irec	10e. Street and Number 10f. Zip Code		1	l 0g. Citizen of What C	Country?
be filed within 72 hours after death with the Maryland	of other than "natural", or liems 23a or 28a-f show event, the Madral Examinat must be notified at	Funeral Director	8288 Woodward Street 20763			USA	
er de	itema	une	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Yes 2 No	Origin? (Spec can, Puerto R	cify Yes or No- lican, etc.)	14. Race - Am Black, Wh	
urs af	al', or	þ	If Yes, Give 1 ☐ Yes 2 💆 No Specification of the	ify:		Specify: (	1hite
72 ho	natur	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during mo	ost of working	a	16b. Kind of Busines	s/Industry
within	than.	ldm	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker			Own Hom	12
De la	and Mental hygiene. Is marked other than aumatic event, the M			ther's Name	(First, Middle,	Maiden Sumame)	ie
ed blu	rked c	To Be	Harold Taylor Ma	urtha M	lason		
2 should	is ma	ľ	19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street and Num</i>			-	
1 and	om 27 ther tr		Rockford S. Mills, Sr. / Son 1108 Hoods Mill  20a. Method of Disposition (Name of Disposition	Road,		ne, Maryla 20c. Location - City o	
Pages	k; if it		20a. Method of Disposition Burial 2 Cremation 3 Removal from State  '4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Geo. Washington Cem.			Adelphi.	
permit. P	Department of neatin and men Important; if item 27 is marke any injury or other traumatic. <u>once.</u>		21. Signature of Funeral Service Licensee 22. Name and Address of Fac	cility Fle	ck Fun	eral Home.	Inc.
<u> </u>	any ir		The Wards Sp. 1601 Sandy Sp.	ring R	load, Li	urer, Mar	yland 20707
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.	as cardiac or	respiratory arr	est,	Approximate Interval Between Onset and Death
	ysician ledical	2 0	Immediate Cause (Final disease or condition resulting in death)  a. Pancreatic cancer				6 months
	aminer		Due to (or as a consequence of):				
T	=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
ecuted	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
S e e	sician	calE	Due to (or as a consequence of).				
tificate	attending physician and I for use as the burial-transit		0.				
th cer	tendin r use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy	NIA	F	23d. Date of d	elivery Day Year
ne dea	the at	ysici	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify)	-		NIF	1
, L.	been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par	rt I.	23e. Did to		to the cause of death?
quires	an sign	ed by	Type I Diabetes		1 🗆 Y	es 2 No 3 1	Probably 4 Unknown
law re	SC	Completed	Coronary artery disease		24a. Was a	sy prior to	autopsy findings available completion of cause of
The	page.	Con			1 Yes	med? death? 2.XNo 1 ☐ Ye	
Sician	s certificete has b director, page 2 s	o Be	examiner?		(Check only or	ne) ence 6 □Other (Sp	anife)
g Phy	ter this neral d	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at			ow injury occurred	<del>o</del> ury)
sendin seath	or: Af the fur	catlo	Accident investigation M 1 Yes 2				
or Att	Direct in by	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28	8f. Location (S City or Town	treet and Number or F n, State)	Rural Route Number,
spital	neral / filled		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date	and place, ar	nd due to the c	ause(s) and manner a	as stated.
DIVISION OF WAR TRECOLDS, T.O. DOA 00100, OUT OUT OUT OF THE HOSpital Or Attending Physician: The law requires that the death certificate be executed	within 24 notis after to teath.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, do and manner stated.	death occurred	d at the time, d	late and place, and du	e to the cause(s)
Tot	Tot	N	29b. Signature and title of certifier  M.D. 29c. License numbe			29d. Date signed (Mor	
17	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	073	1	1114 36	1,2005
1	U		Harry Li, 10780 Hickory Ridge Rd,	, Co	lumb.	ia, M	D21044
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Registr	ar	JUN 0 7 2005 Kentur & Specker				

			For State	State of Mary	land / Depa		Health an		iene (	) 5	18985
			Registrar  1. Decedent's Name (First, Middle, I	Last)	Cer	unicate of	Deaiii	2. Date of Deat	eg. No. h		3. Time of Death
	Physicia		BRENDA	A.	m	ALDNE	•	June	Day	Year	12:45 AM,
	/Medic Examin		4a. Facility Name (If not institution, g	give street and number)		4b. City, Town,			4c. County		10.12.11
			NORTHWEST I	HOSPITAL		RANDA	LLSTO	WN	BAI	TIM	ORE
	Funeral				yrs. last birthday)	If Under 1 Year Months Days		Min. 8. Date of Birth (Month, Day, 07/31/	Year)	9. Birthp	place (State or Foreign ntry) RYLAND
	Director		218-42-3404 Usual Residence of Decedent	¹□M ZXE	59 Yrs.			07/31/	1945	MA	RYLAND
	land ow		10a. State 10b. County	100	c. City, Town or Lo	cation				1	0d. Inside City Limits
	Many a-f sh	tor	MD BALT	TIMORE	GWYNN	OAK					1 ☐ Yes 💥 💆 No
	th the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	Vhat Cour	ntry?
	72 hours after death with the Maryland natural; or Items 23e or 28e-f show used Exam is a must be molified at	ral	5707 PEMBRO	KE AVENUE		212			USA		
	er de	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin an, Mexican, P	n? (Specify Yes or No- Puerto Rican, etc.)		e - Americ k, White,	ean Indian, etc.
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔀 Divorced	d 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1□Yes X□No	Specify:		Specify	BL	ACK
5-0036	2 hou	ted	15. Decedent's	Education	16a. Deced	dent's Usual Occu	pation		16b. Kind of Bu	usiness/Inc	dustry
215	within 7 ene. than "n	Completed	(Specify only highest (Secondary (0-12)	College (1-4or 5+)	life.	kind of work done	auring most of nd)	i working	MITTO	-	
2	be filed within 72 hours after death with the Marylan ital Hygiene.  Identify than "natural", or Itams 23a or 28a-f show other than "natural", or Itams 23a or 28a-f show event, Ital Marisal Examines in usi the molified at	Con				NURSE			MED		
Maryland	d be fil	Be C	17. Father's Name (First, Middle, La LEXIE GARN)					Name (First, Middle, M LLIE STA		1 <del>0</del> )	
Ž	should nd Me mark matic	은	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street	and Number o	or Rural Route Number	City or Town,	State, Zip	Code)
_	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		DANA ANGLIN					VE, BALTI			,
Baltimore,	es 1 a of Hez fitern r othe		20a. Method of Disposition		Ob. Place of Dispo	sition (Name of natory or other pla	ice)	Date	20c. Location -	City or To	own, State
Ĕ	permit. Pages Department of Important: If it any injury or o		XX Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spe	cify)	WOODLAW	N CEMET	ERY 6	/11/05	BALTIN	10RE	CO, MD
Salt	permit. Depart Import any inj		21. Signatur Peral Service Lic	ens	22	. Name and Addre	ess of Facility	HOWELL F	UNERAI	HOI	ME 21207
	707 e d	_	23a, Part Enter the disease, or co	10 /00				HEIGHTS A		LTI	
Ь			23a. Part. Enter the disease, or co stock, or neart trilure. List on Immediat ause (Final	ly one cause on each line.	reath. Do not ent				est,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disea condition resulting in death)	a Crebro		r ac	aden	t			
5-	Examiner			Due to (or as a cor	1sequence of).	here	aton	sion ioniA			
		ner	Sequentially list conditions, if any, loading to introduct cause. Enter Underlying Cause (Disease or injury	b. Die to (or as a cor	rsequence of):	77	- VI-DV	1			
	acuted nd transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· aspra	atron		NEUN	MIRON			
760,	ate be executed nysician and he burial-transit		resulting in Death) Cast	Due to (or as a cor	nsequence of):						
687	physicate to physical	dlcal		d							
×	leath certificat attending phy ifor use as th	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pro	egnancy				23d. Dat	e of delive	erv
Вох	death certifica e attending ph id for use as th	Iclar	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		Ectopic pregnanc Other (specify) _	у		Moi		Day Year
о. О	that the de led by the a detached t	Physician/Med	9 Unknown	9□ Unknown							
	The taw requires that the tee has been signed by the rage 2 should be detached.	ру Р	Part II. Other significant conditions	s contributing to death but no	t resulting in the u	nderlying cause gr	ven in Part I.	23e. Did tob	5.4		ne cause of death?
ord	equir sen si ould I							1 \ Ye	s 2 No	3 Prob	ably 4 Unknown
Records,	taw i	Completed						24a. Was ar autops	v l r	prior to cor	psy findings available mpletion of cause of
								perform 1 ☐ Yes 2	No 1	leath?	2 No
Vital	Physician: this certificantal director,	o Be	25. Was case referred to medical examiner?	Hospital:	a [] 50/0		n de	Death (Check only on			
ō	<u>a</u> ≠ <u>a</u>	-	1 Yes 2 No 27. Manner of Dean	28a. D t of Injury	2 ER/Outpatien 28b. Time of	28c. Inju	ry at	ng Home 5 Reside			V)
<u>o</u>	Attending F ir death. ector: After by the funera	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Day Yea	ar) Injury	M 1	rk? ]Yes 2 □ No				
Division		Certification:	3 Suicide 6 Could not determine		At home, farm, str	eet, factory, office		28f. Location (Sti City or Town		er or Rura	i Route Number,
	Ital or A										
	To the Hospital or within 24 hours after to the Funeral Dirticompletely filled in I	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of my maminer: On the basis of exar and manner stated.	knowledge, death mination and/or inv	n occurred at the ti vestigation, in my	me, date and p opinion, death o	place, and due to the ca occurred at the time, da	luse(s) and ma ite and place, a	nner as st and due to	ated. the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number	25	d. Date signed	i (Month, i	Day, Year)
<b>&gt;</b>	⊢s⊢ő		A Aland	MAN		D439		ī	rang (		2005
	B		30. Name and address of person wh	no completed cause of death	(Item 23a) (Type,	Print) \			vine _		U
	9		Myoka Onein	mp Dol they	way DR	we, 91	in bu	ine. is	P. 21	06%	
	Sta		31. Date filed (Month, Day, Year)	32. Agistrar's S	ghature	-					
	Registr	वा	001101	LUOJ parene	N. Par						

18986

				1 - State Registrar			Certificate (	of Death	F	Reg. No.	
				1. Decedent's Name (First, Middle,	Last)				2. Date of Dea		3. Time of Death
		Physici		Chul Hee	Nam				June	Pay 2 Year 5	10:35 PM
		/Medic Examir		4a. Facility Name (If not institution,	give street and number	er)	4b. City. Toy	m, or Location of De		4c. County of Death	
	1_	Exami	lei	North Aru	indel	Hospita	l Gle	n Bur	nie	Anne A	runde/
		Funeral Director		257-35-6857				ays Hours Mi	8. Date of Birtl (Month, Day 7-27-49	Year) Cou	nplace (State or Foreign untry) ea
		and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
		e Maryli Ba-f sho	Director	Md. Howard			cott City				1 ☐ Yes 2 ☐ No
		s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28s-f show other traumatic event, Ite Medical Exerciter must be notified at		10e. Street and Number 9757 Treybur	n Ct.		10f. Zip Co	21042		10g. Citizen of What Cou Korea	intry?
		er deal	Funerai	11. Marital Status	12. Was Decede Armed Force	s?	13. Was Decedent If Yes, specify	of Hispanic Origin? Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - Amer Black, White	
2	5-0036	ours aft ral', or Evani	þ	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2[ If Yes, Give Year or Date	s:	1 ☐ Yes 2 ☐	No Specify:		Specify: W	hite
0		in 72 h	Completed	15. Decedent's (Specify only highest	grade completed)		Decedent's Usual O Give kind of work d life. DO NOT use r	one during most of w	rorking	16b. Kind of Business/In	ndustry
M. M.	2121	d with giene. or that	E O	Elementary/Secondary (0-12)	College (1-4d		ocery own	er		groce	ry
-	P	be file tal Hy d othe avant,	Be	17. Father's Name (First, Middle, L.					ame (First, Middle,		
	yla	Men Men arka	2	Jung Pil Nam					Yong Chu		
	Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic avent, ILe Magnee.		19a. Informant's Name/Relationshi Myung Ja Nam, w						r, City or Town, State, Zi, $ty$ , $Md$ . $210$	
	Baltimore,	ages 1 ant of He tr. If item y or other		20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other (Special Control		cemetery	Disposition (Name of crematory or other with Memori	place)	Date /05	20c. Location - City or T Marriottsvi	
	altin	permit. P Departme Importan any injuri 2000.		21. Signature of Funeral Service Li		5105010	22. Name and A	ddress of Facility			
	ш	205 2		Shanda L	Kemm		5555 Twi	n Knolls	Rd., Colu	mbia, Md. 2	1045
		Physician		23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	nly one cause on eac	sed the death. Do not hine.		dying, such as cardi	-	rest,	Approximate Interval Between Onset and Death
		/Medical Examiner		resulting in security	Due to (or	as a consequence o	f):				
		sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or	as a consequence o	Ŋ:				
P	/	axecute	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	as a consequence o	f):				
	68760,	certificate be executed iding physician and ise as the burial-transit	/Medical		d						
	9	ertific ling p	Med	IF FEMALE:	20. 16						
	P.O. Box		Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death t at time of death	3 ☐ Ectopic pregr 5 ☐ Other (specif			23d. Date of deliv Month	very Day Year
		uires that t signed by d be deta	by Ph	Part II. Other significant condition	s contributing to deat	h but not resulting in	the underlying caus	e given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
	rds	w requires been sig should b							1 🗀 Y	′es 2 □ No 3 □ Pro	obably 4 Yunknown
	Division of Vital Records,	To the Hospital or Attanding Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attencompletely filled in by the funeral director, page 2 should be detached for	Completed							an 24b. Were aut prior to co death?	topsy findings available ompletion of cause of
	ta	an: tifica tor, p	0	25. Was case referred to medical		/		26. Place of D	1 ☐ Yes eath (Check only o		202110
	f V	Physici this ce al direc	To B	examiner? 1 ☐ Yes 2 🖸 No	Hospital: 1 Inp.	atient 2 ER/Out	patient 3 DOA	Other: 4 Nursing	Home 5 ☐ Resid	lence 6 Other (Speci	rity)
	o uc	iing Ph n. After th funeral		27. Manuar of Death 1 Natural 5 ☐ Pending		njury 28b. Ti Day Year) In	me of 28c. jury M	injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe h	ow injury occurred	
	visio	r Attender death	Certification:	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ot be 28e. Place of	Injury - At home, far , etc. (Specify)			28f. Location (S City or Tow	itreet and Number or Rui n, State)	ral Route Number,
	ā	oital or urs aft aral Dii		./							
		To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the be xaminer: On the basi and manner	s of examination and	death occurred at t /or investigation, in	ne time, date and pla my opinion, death oc	ce, and due to the c curred at the time, o	cause(s) and manner as date and place, and due	stated. to the cause(s)
		To ti withi To ti	Σ	29b. Signature and title of certifier	P (1)	Q TO M		cense number		29d. Date signed (Month)	Day, Year)
		7		30. Name and address of person w	that completed cause	of death (Item 23a)	Type, Print)	(100-3		I WHE I	2000
		10		30. Name and address of person w	Vicks WA	TID, 30	Hospit 10	al Drive	, Glen B	urnie, MU,	21067
		< Sta Regist		JUN 0 7 2	2005	istrar's Signature	foods.				

			For State Registrar	State of Maryland	/ Department of H		ental Hygier	7 11113	18987
			1. Decedent's Name (First, Middle, Last)	/ 20074			2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic	_	JOAN AND				JUNE,	5 2005	4.50 H.M
	Examin	er	4a. Facility Name (If not institution, give si	A VIS	4b. City, Town, or	Location of Death		4c. County of Death  BALTLY	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign
C.	Director		Usual Residence of Decedent	M 200/F 5	Yrs.		11-4-40	· MAI	RYLAND
	yland		10a, State 10b, County	10c. City, T	Town or Location				10d. Inside City Limits
	8a-f s	Director	MD BALTIN	1025	PARKVIlle				1 Yes 2 Mo
	with the	Dire	10e. Street and Number	AVE	10f. Zip Code	731/	10g.	Citizen of What Cou	intry?
	death	Funeral	11. Marital Status 1	2. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe	cify Yes or No-	14. Race - Ameri Black, White	
36	hours after death with the Maryland turet; or items 23a or 28a-f show at Examinational beau diffed at	<b>by</b> Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1	1□Yes 2□No	Specify:	,	Specify: / / )	hite
5-003	"natural", or		15. Decedent's Educ	ation 1	16a. Decedent's Usual Occupa	ation		. Kind of Business/Ir	ndustry
121	within 72 ene. than "nai ha Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done of life, DO NOT use retired,	)	N Y	IN C1.1.	Pi
N	filed w Hygie other t		17. Father's Name (First, Middle, Last)		H. J. C. E	) 18. Moth <i>e</i> r's Name	(First, Middle, Maid	len Sumame)	101/00.
/an	should be filed within 72 ho of Mental Hygiene. marked other than "natur imatic event, Ire Medical	To Be	Charles C. Par	-left SR.		Virgin	ia Nei	phause	R.
Maryland	2 m in m	, 17 d	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing Address (Street a	und Number or Rura	l Route Number, Cit	y or Town, State, Zi	o Code)
	1 and Heall em 2		20a. Method of Disposition	20b. Plac	ce of Disposition (Name of		ate 20c	Location - City or T	own, State
altimore,	0 0 == =		1 Magazial 2 ☐ Cremation 3 ☐ Re  1 Donation 5 ☐ Other (Specify)	emoval from State	netery, crematory or other place 1 Hill Cardens	10.8-	05 1	uddle 16	iver MO
Balti	permit. Pag Department Important: 1 any injury c		21. Signature of Funeral Service Ligense		22. Name and Addres	EDAC	TIMORO,	no 212=	34.
. A	00240		23a. Part1. Enter the disease, or complete	ations that caused the death.	Do not enter the mode of dying			SOO HARIT	Approximate
<b>&gt;</b> F	Physician		shock, or heart failure/ List only on Immediate Cause (Final disease or condition	cause on each line.	NIER, NON-				Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequen		- 17.00			( //(
4 5	, m	e	Sequentially list conditions b. b. if any, leading to immediate	Due to (or as a consequer	nce of):				
V	be executed sician and burial-transit	Examln	cause. Enter Underlying Cause (Disease or injury that initiated events c.						
60,	ite be exe iysician a ne burial-	cal Ex	resulting in death) Last	Due to (or as a consequer	nce of);				
	± × €		d.						
Вох	leath certific attending pl	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal de	eath 3 Ectopic pregnancy			23d. Date of deliv	rery Day Year
0.	at the dea by the at tached fo	Physiclan/Med	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at time of deat 9□ Unknown	th 5 Other (specify)				52,
ري. ص	The law requires that the death certifica tite has been signed by the attending phoage 2 should be detached for use as the	by Ph	Part II. Other significant conditions con-			en in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ord	w require been sig	ted	NON HODG	CINS LYMPU	0 M A		Pes	2 No 3 Pro	bably 4 □Unknown
Records,	hasb ge 2 sl	Completed					24a. Was an autopsy performed	prior to co death?	opsy findings available ompletion of cause of
ta	iician: Th certificate rector, pag	0	25. Was case referred to medical			26. Place of Death	(Check only one)	No 1 □ Yes	2□ No
Division of Vital		To B	1 105 2 2 140	ospital: 1   Inpatient 2   ER			ne 5 Mesidence		fy)
UO .	ding F h. After funera	tlon:	27. Manner of Death  1 Aratural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	8b. Time of 28c. Injury Work  M 1 □ \	rat 2 (? Yes 2 □ No	8d. Describe how in	njury occurred	
Visi	I or Attending Phys after death. Director: After this I in by the funeral di	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	2	28f. Location (Street City or Town, St	and Number or Rur ate)	al Route Number,
٥	oital or urs afte erai Die		_						
	e Hos 24 ho e Fund letely f	edical	29a. Certifier 1 Certifying Phys (Check only one)  1 Certifying Phys  1 Medical Exemin	ician: To the best of my knowle er: On the basis of examination and manner stated.	edge, death occurred at the tim n and/or investigation, in my op	pinion, death occurre	and due to the cause and at the time, date	e(s) and manner as a and place, and due t	stated. to the cause(s)
	To the Hospital or Atternin 24 hours after de To the Funeral Directe completely filled in by the	Me	29b. Signature and title of certifier	-101	29c. License		1	Date signed (Month,	
		- 8	GARY COM						
	17		30. Name and address of person who con	Mb. 6569	N. CUALLET	17.	ANMON	12, MD	21204
75	Sta Registr		31. Date filed (Month, Day, Year) 200	5 38. Registrar's Signatur	" And				

		State of Mar	-	epartme <i>Certifica</i>			and M		giene Reg. No.	05	180	988
	1. Decedent's Name (First, Middle, Last)							2. Date of De	ath	-	3. Time o	of Death
Physician		David A.	Neubre	ch, Sr.				Month June	5, 20	Year 105	10:50	0 PM
/Medical Examiner	An English Money //f and institution -tim	street and number)				4b. City, To	wn, or Loc	ation of Death			1 10.5	0 111
Zamme	11903 Enid Drive					Pot	omac		Montg	omery	7	
Funeral	Social Security Number		In yrs. last birtl		er 1 Year	If Under	24 Hrs. Min.	8. Date of Birl (Month, Da	h V Veer)	9. Birthp	olece (State o	or Foreign
Director	577-44-4632	IM 2□ F	69 Y	rs. Months	Days	Hours		June 25		Washi	ngton	D.C.
P >	Usuat Residence of Decedent  10a. State 10b. County		0c. City, Town	ort pastion							Od Incide C	Sibr Limite
aryle show			oc. City, rown	_						'	0d. Inside C	s 21K] No
vith the Mar or 28s-1 s be notified	Maryland Montgome	ry		Poto					10g. Citizen of \	A/h aA Causa	1-0	
with a or i	11002 End I Design			101. 2	ip Code	854					•	
fler death v	11903 Enid Drive	12. Wes Decedent Eve	arin U.S.	13. Was Dec			nin? (Spe	cifv Yes or No	United	STAT e - Americ		
fter d	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☒ No	0,0.				, Puerto F	cify Yes or No- Rican, etc.)	Blad	ck, White,		
urs a	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Detes:		1 ☐ Yes	2⊠ No	Specify:			Specify	" Whi	.te	
72 ho	15. Decedent's Educ (Specify only highest grade		16a. I	Decedent's Us	uel Occuj	oation during most	of workin	00	16b. Kind of B	usiness/Ind	dustry	
led within 72 holygiene. Ner than "naturalit, the Medical E.	Elementery/Secondary (0-12)	College (1-4or 5+)		(Give kind of w life. DO NOT		d)			C	C -	C	
Sor of the Co.	12		P1	residen	t	40.14.4.	d. Maria	(F) A 6: 4.11-	Compute		Itware	e
2 should be filed within 72 hours after death with the Marylend and Mental Hygiene. and Mental Hygiene. is marked other than "natures; or flow 23a or 28a-f show raumatic event, the Medical Examines must be notified at To Be Completed by Funeral Director	17. Father's Neme (First, Middle, Last)  W. Leroy Neubrech						iet		Maiden Sumen	10)		
d Men d Men marke	19e. Informent's Name/Relationship (Ty)	ne Print)	10h	Mailing Addres	es (Straat				er, City or Town,	State Zin	Code	
d2s than 7 is r	David A. Neubrech,								ryland 2			
Haalth Haalth tem 27 other tr	20e. Method of Disposition		20b. Place of	Disposition (Na	ame of			Date	20c. Location -			
Pages 1 ient of Hi nt: if iten iry or oth	1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		v, c <i>rematory or</i> IWN Memo	-		J <sub>1</sub>	une 9,	Rockvil:	1e. M	arvla	nd
교본본론	21. Signature of Funeral Service License	ю		22 Name a	and Addre	ss of Facility	v					
Depa impo any is	Produc	M	00198						Home/R			
	23a. Part1. Enter the disease, or complishock, or heart failure. List only on			ot enter the mo	de of dyi	ng, such es	cardiac or	respiratory ar	ckville.	MD 2	Approximat	ite
Physician	shock, or heart failure. List only on	e cause on each line.									Interval Bet Onset and	Death
/Medical	Immediate Cause (Final disease or condition	Bronchio	litis C	bliter	ans						Years	
Examiner	resulting in death)	Du	e to (or as a co	onsequen <i>ce</i> of	):					1	rearb	
Da zi		Lung Tra	nsplant	:						1.7	Years	
end end end end	Sequentially list conditions, if eny, leading to immediate			onsequence of								
cate be executed by sician end the buriel-trensit	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events	Idiopath:				osis					Years	
ficate p physics the		Du	e to (or as e co	onsequen <i>ce</i> of)	):							
The law raquiras that tha death certificate be executed ate has been signed by the attending physician end page 2 should be detached for use as the buriel-trensit Completed by Physician/Medical Examil	d											
death e atte ed for	Part II. Other significant conditions con	tributing to death but n	ot resulting in	the underlying	cause giv	en in Part I.		23b. Did t	obacco use co	ntribute to	the cause	of death?
that tha dened by the a detached to Physic								10	res 2½ No	3 ☐ Prot	pably 4□	] Unknown
as that igned be del												
: The law raquire cate has been si pege 2 should I								24a. Was perfo	an autopsy med?	ava	are autopsy	to
law ras be a 2 st										of c	mpletion of death?	cause
The late has pege								*CIN	es 2½ No	10	Yes 2□	] No
ysician: The is certificate diractor, peg	25. Was case referred to medical examiner?	anaital:			O++		of Death	(Check only o	ne)			
his light	1 ☑ Yes 2 ☐ No	ospital: 1 ☐ Inpatient 28e. Date of Injury	2 ER/Out		OA _				lence 6 □Oth		0	
ding Phy h. After thi funaral	1 ⊠Natural 5 ☐ Pending	(Month, Dey Yo		iury	28c. Injui Wo	k? Yes 2⊟h		ou. Describe i	low injury occur	i eu		
Attending Physician: ar death. ector: After this certific by the funaral diractor, tification: To Be (	3 Suicide 6 Could not be	28e. Place of Injury	- At home, farr	m, street, facto			-		Street and Numb	er or Rura	l Route Nun	nber,
tal or Attending Property and Director. After that is director. After that is director. Attent the funaration:	4 Homicide	building, etc. (	Specify)					City or Tow	m, State)			
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A complataly filled in by the fr Medical Certificati		clan: To the best of m										->
he Hospit in 24 hou he Funer iplataly fill	one)	er: On the basis of ex and manner stated	amination end. J.				n occurre					s)
To the compla	29b. Signature end title of certifier	1//				e number	(15		29d. Date signe			
./	1/11/1	e mo			/A Ul	.01050	649		June 6,	2005	)	
5	30. Name end eddress of person who con				***	1						
	Steven D. Nathan, M	[.D. 3300 2. Registrer's		s Koad,	, Fal	.Is Ch	urch	, Virgi	nia 220	42		
State	HIN 0 7 2005	E. A	20 1	and I								

Baltimore, Maryland 21215-0036

**Physician** /Medical **Examiner** 

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 ie marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Modical Examinal must be notified at once.

Pnysician /Medical **Examiner** 

attending physicien and for use as the burial-transit

Be Completed by Funeral Director

၉

# State of Maryland / Department of Health and Mental Hygiene For

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

- State Registrar				Ce	rtificate	e of L	Death			Reg. N	ic. UU	J	103	0 7
1. Decedent's Nam	e (First, Middl	e, Last)							2. Date of D	eath			3. Time of	Death
EULALIO AL	VAREZ 01	_VERA							Month MAY	26	20	Year 005	19:10	М
4a. Facility Name (i	If not institution	n, give street and nu	imber)		4b. City,	Town, or	Location	of Death		4	c. County o	f Death		
3242 VALLE	EYLEE S.				LAUF	REL					ANNE	ARUNI	DEL	
5. Social Security N	lumber	6. Sex	7. Age (In yrs. I	last birthday,	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B	irth	()	9. Birthp	place (State or	r Foreign
212-31-313	33	1∭ M 2□ F	73	Yrs.	Wichting	Days	Hours	141111.	FEB. 12,			MEX		
Usual Residence of	7		140 00											
10a. State	10b. County		10c. City	y, Town or L	ocation							1	I0d. Inside Cit	
MD	ANNE AF	RUNDEL	LA	UREL							_		1XX Yes	2   No
10e. Street and Nu	mber				10f. Zip	Code				10g. C	itizen of Wh	hat Cour	itry?	
3242 VALL	EYLEE S.				207	724				U:	SA			
11. Marital Status		12. Was Dec Armed F	cedent Ever in U.		Was Deced	dent of Hi	spanic Ori	igin? (Sp	ecify Yes or N Rican, etc.)	0-		- Americ	can Indian,	
1 Never Marr	ied 20 Mar		2 🔀 No		1 X Yes :		Specify:		( noarr, 010.)			145	EX I CAN	
3 Widowed	4 Divorced	Year or D	Dates:		120 103 /	2 110	эреспу.				Specify:	111	_A I CAN	
(Spec		t's Education st grade completed)	)	16a. Dece	dent's Usua kind of wor	al Occupa	ation	t of work	ina	16b.	Kind of Bus	iness/Inc	dustry	
Elementary/Seco			(1-4or 5+)	life.	DO NOT us	se retired	)		9					
12		3		C00	K						FOOD S	ERVI	)E	
17. Father's Name	(First, Middle,	Last)					18. Mothe	er's Name	e (First, Middle	e, Maide	<i>n Sum</i> ame	)		
JUAN ALVAR	REZ						TERE	SA OL	VERA					
19a. Informant's N	ame/Relations	hip (Type, Print)		19b. Maili	ng Address	(Street a	ind Numbi	er or Run	al Route Numi	ber, City	or Town, S	itate, Zip	Code)	
ISMAEL ALV	/AREZ / S	SON		3019	PALADIN	V TERF	RACE,	OLNEY	, MARYLA	ND 20	0832			
20a. Method of Dis		_		lace of Dispo	osition (Nan	ne of	e)	1	Date	20c.	Location - C	ity or To	wn, State	
1 ∐ Burial 2X 1 □ Donation	(X)Cremation 5 □ Other (S	3 □Removal from loecify)	State	/WASH C	•		1	LINE 2	2005	1.41	IDE1 M	ADVI /	AND	
21. Signature of Fa			DALI				s of Facili	tv ELE	, 2005 CK FUNER		JREL, M		מאוו	
VX	m ( )	Vec							D, LAURE				)7	
23a, Part I. Ester t	he disease, or	complications that	caused the death	n. Do not en	ter the mod	e of dvino	such as	cardiac	or respiratory a	arrest			Approximate	
shock, or hea Immediate Cause	irt failure. List	only one cause on	each line.						,				Interval Betw Onset and D	
disease or condition	on	a	tatic hep		ular ca	arcino	oma						6 months	S
		Due to	(or as a consequ	uence of):										
Sequentially list co	nditions,	b	desires was a second											
d any, leading to in cause. Enter Unde Cause (Disease or	rlying -	Pae to	(ur as a consequ	aenda or):-										
that initiated events resulting in death)	S	c	/											
rosaning in south)	Lust	Due to	(or as a consequ	uence or):										
		d												
IF FEMALE:														
23b. Was deceden		23c. If yes, ou 1⊟Live	itcome of pregna birth 2  Fetal		∃Ectopic pr	egnancy					23d. Date			
in the past 12	□No	4□Preg 9□Unkr	nant at time of de	eath 5	Other (sp	ecify)					Monti	"	Day Ye	ear
9 Unknown		1												
Part II. Other signif	ficant condition	ons contributing to o	leath but not resu	ulting in the u	nderlying ca	ause give	n in Part I	•	23e. Did	tobacco	use contrib	oute to th	e cause of de	ath?
									1 🗆	Yes 2	2 □ No 3	Prob	ably 1XXVII	nknown
									24a. Was		24b. We	ere autor	psy findings a	vailable
									auto	psy ormed? 2 X N	Ori	ior to con ath?	mpletion of ca	use of
25. Was case refer	red to madica						00 81-	( D			lo 1 L	⊒ Yes	2 U No	
examiner?	,	Hospitals	Innation: 0	ED/0		A Othe			(Check only		• 🗆 🗀	/0	1999-1272-11	W-947.5
1 Yes 2 X				ER/Outpatier 28b. Time o		1	46110	-	me 5 Res 28d. Describe				POSP II	CE
1 🕅 Natural	5 Pendin	9	of Injury oth, Day Year)	Injury	M	8c. Injury Work	? ′es 2 □				, 00001180	-		
2 Accident 3 Suicide	6 Could	not be	e of Injury At he	mo ta			الماع دن		28f Location	(Ctront -	and Alumba-	ror Pura	I Doubo Alivert	201
4 - Homicido	determ	ined   200. Flace	e of Injury - At ho	, io, idilli, Si	col, lactory	, onice			28f. Location	2119619	ara reamber	or Hura	A LOUIS LANLUD	0/1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and Division of Vital Records, P.O. Box 68760,

> State Registrar

completely filled in by the funeral director,

Medical Certification: To Be Completed by Physician/Medical Examiner

29a, Certifier

4 Homicide

29b. Signature and fittle of certifie

Ýlene A. Larsen, M.D.

31. Date filed (Month, Day, Year) 105

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Chevy Chase, Maryland 20815

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

5530 Wisconsin Avenue #930,

32. Registrar's squature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Virginia Wilson Burt O'Sheel 31 2005 12:00 P.M. May /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Maplewood Park Place Health Care Montgomery Bethesda if Under 1 Year | If Under 24 Hrs. | 5. Sociel Security Number 6 Sex 7. Age (In vrs. lest birthday) 8. Date of Birth (Month, Day, August 1, 9. Birthplace (State or Foreign Country) West Virginia **Funeral** Months Deys 1 □ M 2 1 F Yrs. 232-24-0326 92 Director Usuel Residence of Decedent 10a. Stete 10b. County 10c, City, Town or Location 10d. Inside City Limits

10f Zin Code

20814

1 ☐ Yes 2 ☑ No Specify:

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.)

Bethesda

12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

1 ☐ Yes 2 🕅 No

Approximate Interval Between Onset and Death

24b. Were autopsy findings

available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

10g. Citizen of What Country?

United States

14. Race - American Indian, Black, White, etc.

Specify: White

16b. Kind of Business/Industry

r than "natural", or items 23a or 28a-f shor the Medical Examiner must be notified at Pages 1 and 2 should be filed within 72 hours efter 27 is marked of traumatic ever Important: If It any injury or o

Maryland

11. Marital Status

10e. Street end Number

Directo

Funeral

۾

Montgomery

15. Decedent's Education (Specify only highest grede completed)

9707 Old Georgetown Road

1 ☐ Never Merried 2 ☐ Married

31☑ Widowed 4 Divorced

Baltimore, Maryland 21215-0020 **Physician** /Medical Examiner

requires that the death certificate be executed physician s the burie attending I Vital Records, P.O. ō Division ō To the Hospital of within 24 hours at To the Funeral D completely filled in Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick A. Burt Nina Virginia Brown 19a, informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Margaret Ellen O'Sheel/Daughter #3 Greville Close, Twickenham, United Kingdom TW1-3HR 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition June 3, 2005 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bethesda, Maryland Montgomery Crematorium 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, 21. Signature of Funeral Service License M01433 Bethesda, Maryland 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Due to (or es a consequence of): Examine Coronary Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Dysphagia Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) Necrotic Diabetic Foot Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown Diabetes Mellitus ۵ Completed 24a. Was an autopsy performed? Pneumonia 1 ☐ Yes 2 🕅 No Peripheral Artery Disease 25. Was case referred to medical examiner? B 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 41 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

DHMH 16 Rev 6/95

edical

Σ

State

Registrar

(Check only

29b. Signature and title of certifier

31. Dete filed (Month, Day, Yeer)

er

JUN 0 7 2005

. Registrar's Signature

30. Nome end address of person who completed cause of death (Item 204) (Type, Print)
Merlyn K. Vemury, M.D., Ph.D. 9801 Georgia Avenue, Silver Spring, Maryland 20902

			1 - For State Registrar	State of M		partment of ertificate of		nd Mental Hy	giene	5	8991
ı	Physic		Decedent's Name (First, Middle, Last,     Joseph Adam Posit					2. Date of De June		Year	3. Time of Death 5:10 p м
	/Medi Exami		4a. Facility Name (If not institution, give	le		Belc:			На	nty of Death	.I
	Funeral Director		5. Social Security Number 6. Sec. 213-05-8831 15		ge (In yrs. last birthda 86 Yrs	Months Da		Min. March	<sup>rth</sup> , Year 919	9. Birthp Coun	place (State or Foreign ntry) ryland
	72 hours after death with the Maryland natural", or Items 23a or 28a-f show after Examitien: sust be redified at	ector	Md. Harford  10e. Street and Number		10c. City, Town or	Fallston			10 000		1 Od. Inside City Limits 1 ☐ Yes 2 No
	s 23a or	Funeral Director	602 Westbury Road				L047			.S.A.	itry?
9000	72 hours after death with the Maryla natural; or Items 23a or 28a-1 shours or 25a-1 should be a rectified at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1Yes 2 If Yes, Give Year or Dates:	Ever in U.S. 1	3. Was Decedent of If Yes, specify C		n? (Specify Yes or No Puerto Rican, etc.)	Spec	ace - Americ lack, White, o	
21215-0036	d within giene. r than "	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12 years		5+) (Gi	cedent's Usual Oc ve kind of work do b. DO NOT use ret pervisor	ne durina most o	of working	16b. Kind of		dustry
Maryland	ges 1 and 2 should be filed to f Health and Menial Hygi If itam 27 is markad other or other traumatic avant,	To Be	17. Father's Name (First, Middle, Last) Peter Posinski				Ste	Name (First, Middle 11a Conrac	, Maiden Suma 1	ame)	
	is 1 and 2 sho of Health and itam 27 is m other traum		19a. Informant's Name/Relationship (Ty.  Michael Posinski,  20a. Method of Disposition	. ,	60			Fallston	, MD 21	047	
Baltimore,	t. Pa rtmer rtant		1  Burial 2 □ Cremation 3 □ R  '4 □ Donation 5 □ Other (Specify)  21. Signal or 1/Fu/Per: Service License		cemetery, c	w Mem. Go	lns. 6	/6/05		ton, M	ſd.
B B	Depa Impo any ii		* Chilly		the death. Do not a	610 W.	MacPhai	ral Home of Road, Be	el Air.	Md. 2	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Caupg (Finadisease or condition resulting in death)	Alz	a consequence of):	Arm	- 6				Interval Between Onset and Death
68760,	icate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last		a consequence of):						
.O. Box	death certiff a attanding d for use as	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnar				ate of deliver	ry Day Year
Records, P	The law requires that the tee has been signed by though 2 should be detached.		Part II. Other significant conditions con	tributing to death bi	ut not resulting in the	underlying cause	given in Part I.	23e. Did to			e cause of death?
		Completed								Were autop prior to com death? 1 Yes 2	osy findings available apletion of cause of
Division of Vital	a the	ation; To Be	25. Was case referred to medical examiner?  1  Yes 2 No H.  27. Manner of Death  1 Natural 5 Pending investigation	ospital: 1  Inpatie 28a. Date of Injur (Month, Day	y 28b. Time	of 28c. In	ther: 4 Nursir	Death (Check only on page 15 The Residual Castribe has 15 The Residual Cas	lence 6 🗆 Ot		)
Divis	To the Hospital or Attanding within 24 hours after death.  To the Funaral Diractor: After completely filled in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	building, etc				28f. Location (S City or Tow	m, State)		
	To the Hospital within 24 hours of To the Funaral completely filled	Medicai	29a. Certifier (Check only one)  1 Cartifying Phys 2 Madical Examin	er: On the best of and manner sta	examination and/or	nvestigation, in my	opinion, death o	occurred at the time, o	date and place,	, and due to t	the cause(s)
٠	J. Wild		29b Signature and title of certifier	Mu	nn	D'	2 ) 9 7 3	5	29d. Date signe	od (Month, D	ay, Year)
	Sta	10	30. Name and address of person who cor 31. Date filed (Month, Day, Year)	Clure	MIN	Print) M	ac Abai	Ind A	el An	, un	21014
	Registr	-	JUN 0	7 2005	Borne A	Coast	-				

David Petersen 05-03677 NJM

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

an	Decedent's Name (First, Middle,	Last)				2. Date of De Month	Dav	Yeer	3. Time of D
cal	David Andre		ak			May	28	2005	0755
ner	4a. Facility Name (If not institution, g				or Location of Death		1 .	County of Death	
	Holy Cross Hosp		um laat hirth		Spring If Under 24 Hrs.	9 Date of Bi		lontgome	
	5. Social Security Number 213–58–6472	1 XM 2 F 47	yrs. last birtho Yr	Months Days	Hours Min.	8. Date of Bir (Month, Da	ay, Year)	Cour	place (State or I ntry) .inois
	Usuel Residence of Decedent	Α 47				Sept.	9, 13	7.77	THOIS
	10a. State 10b. County	10	c. City, Town o	or Location				1	10d. Inside City
ctor	MD Mon	tgomery	Silv	er Spring					1 ☐ Yes 2
Director	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What Cour	ntry?
<u>a</u>	3323 May Stre			20906				ited Sta	
Funer	11. Marital Status	12. Was Decedent Ever Armed Forces?	_	<ol> <li>Was Decedent of If If Yes, specify Cub</li> </ol>	Hispanic Origin? (Sp ean, Mexican, Puerto		o- 1	<ol> <li>Race - Americ Black, White,</li> </ol>	
by F	1. Never Married 2 Married 3 Widowed 4 Divorced	d 1 □ Yes 2 □ No If Yes, Give Year or Dates:	1977-	1 ☐ Yes 2 ☐XNo	Specify:			Specify: W	hite
	15. Decedent's			ecedent's Usual Occur	pation		16b. Kir	nd of Business/In	dustry
plet	(Specify only highest	grade completed)	((	Give kind of work done ife. DO NOT use retire	during most of work	ing	_	dening	
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Gardener			Br	cookside	
0	17. Father's Name (First, Middle, La	est)			18. Mother's Name	e (First, Middle	, Maiden :	Sumame)	
ToB	Gerald Andrew	Petersen			Eunice	Joyce	Brow	vn	
	19a. Informant's Name/Relationship	(Type, Print)	19b. N	Mailing Address (Street	and Number or Rura	al Route Numb	er, City or	Town, State, Zip	Code)
	Eunice Joyce Br			3323 May St					906
	20a. Method of Disposition		Ob. Place of D cemetery,	isposition (Name of crematory or other pla	ce)	Date		cation - City or To	
	1 ☐ Burial 2√5 Cremation 3  `4 ☐ Donation 5 ☐ Other (Spe	cify)	Chesape	eake Cremat	tory 6/1/	05	Bel	tsville	, MD
	21. Signature of Funeral Service bid			22. Name and Addre Rapp Fune:	ass of Facility	ematio	n Ser	wices	
	Steply Do Jole	ruscum M	00382	933 Gist	Avenue Sil	ver Sp	ring,	MD 20	910
	Immediate Cause (Final disease or condition resulting in death)	a. Atheroscl Due to (or as a co		Cardiovaso	cular Dise	ase			Interval Betwee
caminer	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter thiodrying Cause (Disease or injury that initiated events	Due to (or as a co	onsequence of)		cular Dise	ase			
Medical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter this original cause. Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of)		cular Dise	ase			
cian/Medicai	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter thiodrying Cause (Disease or injury that initiated events	Due to (or as a co	onsequence of) onsequence of) onsequence of) regnancy Fetal death			ase	2	3d. Date of delive	Onset and De
by Physician/Medicai	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	Due to (or as a co	onsequence of) onsequence of) onsequence of) regnancy   Fetal death e of death	: : : 3 □ Ectopic pregnanc 5 □ Other (specify) _	у	23e. Did 1	obacco us		ery Day Yes
eted by Physician/Medical	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter this critical cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	Due to (or as a co	onsequence of) onsequence of) onsequence of) regnancy   Fetal death e of death	: : : 3 □ Ectopic pregnanc 5 □ Other (specify) _	у	23e. Did 1	obacco us Yes 2	Month se contribute to tl	ery Day Ye be cause of dee
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o Be Completed by Physician/Medical	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter browning Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant condition	Due to (or as a co	ensequence of) ensequ	:  3 □Ectopic pregnanc 5 □ Other (specify) □ he underlying cause give	y ven in Part I. 26. Place of Deat	23e. Did 1 1  24a. Was auto performance in Silves on (Check only of	an psy 2 No one)	Month se contribute to the secont of the secont of the second of the sec	ery Day Yes  the cause of dee pably  popsy findings av mpletion of cau
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DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** John Peyton Jr. 25, May 2005 9:25P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner LaPlata Civista Medical Center Charles 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Va. **Funeral** Months 1**X** M 2□F 225-60-1976 59 Director 03-31-46 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Va. 1 ☐ Yes 2 ☐ No Director Westmoreland King George 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17503 Ridge Road 22485 U.S.A Funerai 12. Was Decedent Ever in U.S. Amed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 5ollege (1-4or 5+) Technician U.S. Govt. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lillian John A. Peyton Sr. McDowney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta Peyton(Spouse) 17503 Ridge Rd.King George, Va.22485 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Peyton Family Cem. 5-31-05 King George, Va. <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funeral/Service MARSHALL'S FUNERAL HOME/ FISHER FUNERAL HOME 4308 SUITLAND RD. SUITLAND, MD / OLDHAMS, VA Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician 5 arcoidosis disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Con Sequentially list conditions, any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) the 9☐ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificate 2 46 1 Yes 1 Yes 2 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No Inpatient 2 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5/257 D-45737 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nirmaladevi Jayanthan, MD 3328 Old Washington Rd Waldorf, MD 20602 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 7 2005 Registrar

DHMH 17 Rev 1/2001

John Peyton

			1 - State Registrar	ate of Maryla		artment of H			iene 19, No. 005	18994
	Physici		1. Decedent's Name (First, Middle, Last)	Lucille	Payne			2. Date of Death Month	n 2, 2005 Yea	3. Time of Death
-	/Medic Examir		4a. Facility Name (If not institution, give stree		7,	4b. City, Town, or			4c. County of De	ath
	Funeral Director		5. Social Security Number 6. Sex 1 □ M	7. Age (In y	rs. last birthday) 55 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. B	irthplace (State or Foreign Country) Maryland
	anyland show	7.	Usual Residence of Decedent  10a. State  10b. County  Maryland  N/A	10c.	City, Town or Lo		timore			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	death with the Maryland ms 23a or 28a-f show	Director	Maryland N/A  10e. Street and Number  1507 Northwick Road			10f. Zip Code	21218	10	Og. Citizen of What (	Country?
136	be filed within 72 hours after death with the Marylan tal Hygiene. d other than "natural", or Items 23s or 28s-f show avent, the Medical Evantiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married	Vas Decedent Ever in timed Forces?  Yes 2 M No if Yes, Give Yes or Dates:	1	Was Decedent of Hi f Yes, specify Cubar 1 ☐ Yes 2 No	spanic Origin? (5	Specify Yes or No- to Rican, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, nite, etc. Black
9500-51212	be filed within 72 hours after tal Hygiene. d other than "natural', or Ite avent, the Medical Exa⊤line	Completed	15. Decedent's Educatio (Specify only highest grade cor Elementary/Secondary (0-12)	n npleted) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired, Home	uring most of wo	prking	16b. Kind of Busines	s/Industry
Maryland		To Be C	17. Father's Name (First, Middle, Last)  John Sco	ott			18. Mother's Na	me (First, Middle, M Cla	faiden Sumame) ra Scott	
_	127 E		19a. Informant's Name/Relationship (Type, I Tiffany Payne Daughter		15	07 Northwick		more, Marylan		
Baltimore,			20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ Remo  `4 □ Donation 5 □ Other (Specify)	val from State	Garrison Fo	rest Veterans	Cemetery	Date 2 06/08/05	20c. Location - City of Owings	or Town, State Mills, Md
Bal	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licensee	ann.		1300 Eu	others Fune taw Place B	eral Service PA altimore, Md 2	2121/	
-	Physician /Medical		23a. Part1. Enter the disease, or complicatic shock, or heart failure. List only one call mmediate Cause (Final disease or condition resulting in death)	ons that caused the duse on each line.  Due to (or as a cons	onau	er the mode of dying	g, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death
8/60,	death certificate be executed e attending physician and ad for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last  d	Due to (or as a cons	Car sequence of):	cer				years
O. Box 6	ath certif attending for use a	Physician/Me	in the past 12 months?	yes, outcome of pre □Live birth 2 □ F □ Pregnant at time o □ Unknown	etal death 3 [	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
ecords, P.	The law requires that the de tite has been signed by the vage 2 should be detached	by	Part II. Other significant conditions contribu	ting to death but not	resulting in the ur	nderlying cause give	n in Part I.	23e. Did tob		to the cause of death?  Probably 4 □Unknown
r	The lay	Completed						24a. Was an autopsy perform	prior to death?	autopsy findings available completion of cause of
on of Vital	ding Phys I. After this funeral dir	tion: To Be	25. Was case referred to medical examiner? 1  Yes  2  No  Hospi  27. Manper of Death 1  Natural  5  Pending 2  Accident investigation	tal: 1 Inpatient 2 Ba. Date of Injury (Month, Day Year	2 ER/Outpatien 28b. Time of Injury	28c. Injury Work	4 Nursing I	ath (Check only one Home 5 Resider 28d. Describe how	nce 6 Other (Sp	ecify)
DIVISION	al or Attendates after death	Certification:	2 Suicido 6 Could not be	Be. Place of Injury - A building, etc. (Spe	at home, farm, streecify)	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or F State)	Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one) 1 Certifying Physicie 2 Medical Examiner:	n: To the best of my On the basis of exam and manner stated.	knowledge, death sination and/or inv	occurred at the tim restigation, in my op	e, date and place inion, death occi	e, and due to the caurred at the time, da	use(s) and manner a te and place, and du	as stated. se to the cause(s)
•	To t withi Com	2	29b. Signature and title of certifier	I Ster	ne	29c. License	number 40	3	d. Date signed (Mor	nth, Day, Year)
1	)		30. Name and address of person who completed the second se	Stei	ner	Print) 560 (	Coc	4 Rac	ren B	(vd
	Sta Registi		JUN 0 7 2005	32. Mgistrar's Si	gnature	and)				

		1 - For State Registrar		ryland / Depa <i>Cei</i>	rtificate of L		F	Reg. No.	5   8995
Physici /Medi		1. Decedent's Name (First, Middle, La	•	e Pegesse	•		2. Date of Dea Month		3. Time of Death 9:05 Am
Examir		4a. Facility Name (If not institution, giv	e street and number) Idercare-Perring	Parkway	4b. City, Town, or	Location of Death Baltime	ore	4c. County o	f Death
Funeral Director		5. Social Security Number 6. S 139-22-5879		(In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs, Hours Min.	8. Date of Birti (Month, Day Apr 24,	1913	9. Birthplace (State or Foreign County) Virginia
he Maryland 8a-f show dilleu at	Director		/A	10c. City, Town or Lo	Balt	imore			10d. Inside City Limits X 1 Yes 2 No
th with th	al Dire	10e. Street and Number 5913 Loch Raven Blvd.			10f. Zip Code	21239		10g. Citizen of Wi	nat Country? J.S.A.
s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 Is marked other then "naturel, or items 23e or 28e-f show other treumatic event, the Medical Ever, it within the modified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1Yes 2 X N If Yes, Give Year or Dates:	0	Was Decedent of His f Yes, specify Cuban 1 ☐ Yes 2 No	spanic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black Specify:	- American Indian, White, etc. Black
within 72 h iene. then "natu	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade co <i>mpleted)</i> College (1-4or 5-	(Give	dent's Usual Occupat kind of work done du DO NOT use retired) Home	tion uring most of worki emaker	ing	16b. Kind of Bus	iness/Industry Home
d be filed ental Hyg ced other c event,	Be	17. Father's Name (First, Middle, Last	Unk			18. Mother's Name	e (First, Middle, Annie	Maiden Sumame May Young	) ]
d 2 7 Is	To	19a. Informant's Name/Relationship ( Reign Pegesse -Collick		19b. Mailin	ng Address (Street ar 06 Frankford /	nd Number or Rura Ave. Baltimo	re , Md. 212	r, City or Town, S 214	tate, Zip Code)
permit. Pages 1 and Department of Heali Importent: If item 2 eny injury or other <u>once</u> .		20a. Nethod of Disposition  1		20b. Place of Dispo cemetery, cren Morelan	sition (Name of natory or other place d Garden		1		re, Md.
permit. Departr Importe eny inje		21. Signature of Fur ral Service Lice	nsee	22	Name and Address Estep Bro 1300 Eut	of Facility others Funera aw Place Bal	al Service P	A	
Pnysician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aa.	9.	er the mode of dying.		or respiratory arr	est,	Approximate Interval Between Onset and Death
tificate be executed g physician and as the buriat-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Unidentlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):					
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at the 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Monti	
w requires that s been signed b	by	Part II. Other significant conditions of	contributing to death but	t not resulting in the ur	nderlying cause giver	n in Part I.			ute to the cause of death?
	Completed						24a. Was a autops perform	ned? prid	ere autopsy findings available or to completion of cause of ath? ] Yes 2 [] No
Physicien: The this certificate had director, page	o Be	25. Was case referred to medical examiner?  1 Tyes 2 No	Hospital: 1 ☐ Inpatien	t 2 ER/Outpatien	Othor	26. Place of Death		ence 6 □Other	(Specify)
ng l	ation: T	27. Manny of Death 1 Vatural 5 Pending 2 Accident investigation	1	Year) 28b. Time of Injury	28c. Injury a Work? M 1 \( \sum Ye	at 2		ow injury occurred	
tal or Atters after de el Directe ed in by te	Certification:	3 Suicide 6 Could not b 4 Homicide determined		y - At home, farm, stre (Specify)	eet, factory, office	2	28f. Location (St City or Town	reet and Number n. State)	or Rural Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	29a. Certifier 1 Sertifying Pr (Check only one) 2 Medical Exam	ysician: To the best of niner: On the basis of a and manner state	examination and/or inv	occurred at the time restigation, in my opin	e, date and place, a nion, death occurre	and due to the ca ed at the time, d	ause(s) and mann ate and place, an	ner as stated. d due to the cause(s)
To t To t	M	29b. Signature and little of certifier	ec mn		29c. License				Month, Day, Year)
2		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type, I	Print) Drug la	1855 Ristral	Bil	L'ane o	, 2005 4021234
Sta Registr		31. Date filed (Month, Day, Year)  JUN 0 7 2	005 32 egistrar	's Signature	and or	/	. varo	imo //	10 -10-57

	•	For State Registrar	State of Maryland		ment of He ficate of D			eg. No.	105	13996
Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Shirles H.	PORTER				2. Date of Dea Month JUNE	Day 2,		3. Time of Death 7:30 P. M
Examin		4a. Facility Name (If not institution, give s  12240 ROUNDWOOD  5. Social Security Number 6. Sex	ROAD  7. Age (In yrs. las		MAYS Under 1 Year	CHAPEL If Under 24 Hrs.			BALTII	10RE
Funeral Director			M <b>३(</b> )XF 80	Yrs. M	onths Days	Hours Min.	8. Date of Birth (Month, Day 12-18-	1924	M/	nplace (State or Foreig untry) ARYLAND
a-f show	ctor	MD. 10b. County BALTIM		Town or Location	on MAYS	CHAPEL				10d. Inside City Limits
13a or 28	ai Director	10e. Street and Number 12240 ROUNDWOOD	ROAD	1	10f. Zip Code 21	093	1	0g. Citize	on of What Co	•
I arruz stroug be fixed within 72 froms after death with the maryand the marked of the marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at	ed by Funerai	1 ☐ Never Married ★★ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U.S. Armed Forces?  1 Yes NO No If Yes, Give Year or Dates:	If Ye	Yes 2XXNo	Specify:	pecify Yes or No- Rican, etc.)	S	I. Race - Ame Black, White pecify:	WHITE
giene. er than "na! t, the Medic	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12 YEARS		(Give kind life. DO l	's Usual Occupa d of work done di NOT use retired)	uring most of wor	king	OW	of Business/I	,
and Mental Hygiene. is marked other than aumatic event, the Ma	To Be	17. Father's Name (First, Middle, Last) FRAN			į	НА		RNER		
nent of Health and int: If item 27 is m iry or other traum		19a. Informant's Name/Relationship (Type JOHN M. PORTER  20a. Method of Disposition  1 X Purial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)	(HUSBAND)  20b. Plac	12240 ce of Disposition netery, cremato	ROUNDWO	OD ROAD,	Date	APEL 20c. Loca	,MARYLA	ND, 21093
Department of Important: If i any injury or once.		21. Signature of Funeral Sarvice License		22. Na	ame and Address	of Facility	L HOME,I		1050 Y	
nysician Medical xaminer		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. e cause on each line.  Due to (or as a confequence)	men	Λ-	, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
physician and the burlal-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	nes	S Con	acet				2 year
by the ettending parached for use as t	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yo 9 ☐ Unknown	ic. If yes, outcome of pregnanc  1	eath 3 Ect	opic pregnancy her (specify)			23	d. Date of deli	very Day Year
gned be de	by	Part II. Other significant conditions cont	nbuting to death but not resulti	ng in the under	rlying cause giver	n in Part I.	23e. Did tol			the cause of death?
certificate has been signed by the ettending rector, page 2 should be detached for use as	Completed						24a. Was a autops perform	y	prior to c death?	opsy findings availab ompletion of cause of 2 No
fter this	tion; To Be	25. Was case referred to medical examiner?  1  Yes		8b. Time of Injury	DOA Other	4 Nursing Ho	th (Check only on ome 5 Reside 28d. Describe ho	nce 6	Other (Spec	ify)
within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street,	factory, office		28f. Location (St City or Town		Number or Ru	al Route Number,
n 24 hours he Funera pletely fille	edical	29a. Certifier (Check only one)	cian: To the best of my knowle er: On the basis of examination and manner stated.	edge, death occ n and/or investi	curred at the time	, date and place, nion, death occur	and due to the carred at the time, d	ause(s) ar ate and p	nd manner as lace, and due	stated. to the cause(s)
To t com	Z	29b. Signature and title of certifier	mbere of	7	29c. License				signed (Month	Day, Year)
5		30 Name and address of person who con	npleted cause of a ath (Item 2	a) (Type, Print	t)	[a, 6]	Balle	0	2120	

		•	, FOI	partment of Health and Nertificate of Death	Mental Hygie	AUUU IDJJI
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year
	Physici /Medic		Harding Penny		May 3	Day 7005 2,004 M
*	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Mosts Armalel Hospital	If Under 1 Year If Under 24 Hrs.	かって	Ann Hundel
п	Funeral Director		5. Social Security Number 6. Sex 7. Age (In rs. last birthda) 411-16-1080 83 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Sept. 8	9. Birthplace (State or Foreign Country) 1921 N. Carolina
			Usual Residence of Decedent		pept. o	1921 N. Calonina
	rylan	_	10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Be-f s	Director	Maryland Anne Arundel   Gambril			1 ⊠Yes 2 □ No
	with th	Dire	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	eath v	Funeral	2546 Symphony Lane  11 Marital Status 12. Was Decedent Ever in U.S. 13	21054  3. Was Decedent of Hispanic Origin? (Sp	ecity Ves or No-	USA 14. Race - American Indian,
10	fter de	Fun	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married ※☑ Married 11∑ Yes 2 □ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
036	72 hours after death with the Maryland naturel; or teme 23a or 28e-f show Jisul Examiner in the mullified at	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: W.W. 11	1 ☐ Yes 2 ☐ No Specify:		Specify: Black
21215-0036	within 72 hours after death with the Marylaniene. iene. r then "naturel", or lieme 23a or 28e-f show Itte Medical Examilier in ust be mullied at	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation we kind of work done during most of work	ing 16b	. Kind of Business/Industry
121	within ene. then "	Idm	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		
			12th 0 Chi	ef Warrant Offi	cer L e (First, Middle, Maid	JS Government
Maryland	be be	To Be	Charles W. Penny		Boston	
ary	2 should be and Menta is marked eumatic e	۳	1	iling Address (Street and Number or Rui		ity or Town, State, Zip Code)
	27 rtr		Eugenia V. Penny (Wife) 2546	Symphony Lane	Gambril1	s, Md. 21054
ore	·		20a. Method of Disposition  20b. Place of Disposition  20b. Place of Disposition  20cametery, cr	ematory or other place)	Date 200	. Location - City or Town, State
Ĕ	Pages ment of I ent: If its lury or o		'4 Donation 5 Other (Specify) Arlingt	on National 8/1	1/05 Ar	lington, Virginia
Baltimore,	permit. Page Department of Importent: If any injury or once.			22. Name and Address of Facility Wm. Reese & Son	s MOrtua	rv, P.A.
	40 = e d		23a. Part 1. Enter the disease, or complications that caused the death. Do not e	Wm. Reese & Son 821 West St. An	napolis,	Md. 21401 Approximate
4	2 -		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	Renal 1	1 2	Interval Between Onset and Death
П	Pnysician /Medical		disease or condition resulting in death)  a	1 -0121	* Y 1 'V "	
	Examiner			I- abetis		
	7 =	ner	Sequentially list conditions, if any, teating to immediate cause. Enter Underlying	1400 600		
	icate be executed physician and s the burial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a conseque S. u.)	2 Towns		
60,	be exician sourial	E E	resulting in death) Last Due to (or as a conseque \$ \( \eta \):			
68760,		edical	d.			
Box (	eath certific attending pl	J/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
١.	death e atte	icia	in the past 12 months?  1 Ves 2 No.  4 Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		Month Day Year
P.0	The law requires that the death certif site has been signed by the attending bage 2 should be detached for use as	Physician/M	9 Unknown			
	es that igned to be det	by F	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the cause of death?
ord	w requir been si should	ted	02001-41 119		1 Yes	2 No 3 Probably 4 Unknown
Records,	e taw has b	Completed	L		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
al F					1 ☐ Yes 215	
Vital	Physicien: Tribis certifical ral director, p	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 Nupatient 2 ☐ ER/Outpati	Othor	h (Check only one)	C C Other (Creek)
of	g Phys er this eral di		27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how i	e 6 Other (Specify)  njury occurred
ion	utending I death. ctor: After y the funer	atlo	1 Statural 5 Pending (Month, Day Year) Injury 2 Accident investigation	M 1 Yes 2 No		
Division	of or Attence after death Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S.	t and Number or Rural Route Number, tate)
	Hospitet or Attending 44 hours after death. Funeral Director: Atte tely filled in by the fune					
	To the Hospitel or within 24 hours after To the Funeral Direction completely filled in b.	edical	29a. Certifier (Check only one)  29a (Certifying Physician: To the best of my knowledge, deal (Check only one)  29a (Certifying Physician: To the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and tyle of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	,- , ,- 0		m)	1)48006	0	6/01/2005
	6+1		30. Name and ad ress of person who completed cause of death (Item 23a) (Type	e, Print)	1. 77	mni+ mD 41061
	¥		31. Date filed (Month, Day, Year)  32. Registrar's Signature	rosyr or 1	م سار	1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1
	Sta Registr		JUN 0 7 2005	and a		
			OUT VI LOVO DIRECTOR AND AND AND AND AND AND AND AND AND AND			

DHMH 17 Rev 1/2001

Henching Panny

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** JUNE 6, RUBACH 2005 2:58  $\mathbf{A}^{\mathsf{M}}$ KARL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPICE OF THE CHESAPEAKE LINTHICUM ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. August 3, August 3, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year 1927 Months 1**▼**M 2□F Florida Yrs. Director 573-24-2200 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a, State 10b. County 10d. Inside City Limits 28e-f show Examiner must be notifled at 1 Tyes ZYNo Prince George's Bowie Maryland Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5 USA 12405 Ryland Court 20715 or Items 23a Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1XXes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2KXio Specify: ģ Year or Dates: Korea 3 ☐ Widowed 4 ☐ Divorced "naturel', Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) other than Appraiser Real Estate 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any injury or other treumatic event <u>QNCB</u>. Be Gertrude Mildebreth Carl Rubach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4202 Mystic Trail, Mansfield, Texas 76063 Erik K. Rubach / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore-Washington | 6-13-2005 Laurel, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Witzke Funeral Home of Catonsville 1630 Edmondson Ave. Baltimore, MD 21228 21. Signature of all Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear/failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Tacnocarc enom disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown nis certificate has been signed by t I director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy pertormed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No or Attending Physicien: Be 25. Was case referred to medical examiner? / 26. Place of Death (Check only one) No No Other: 1 Tes Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Ceath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred funeral After 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident investigation the f 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

one)

31. Date filed (Mor.

29b. Signature and title of certifier

11111

LOUISE STOMIEROWSKI, M.D., 1396 PICCARD DRIVE, ROCKVILLE, MARYLAND

tmerrisk

32. Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

JUNE 6, 2005

			1 - For State Registrar		Maryland / Do	epartment Certificate			and Me		giene Reg. No.	005	18999	
	Physici	an	1. Decedent's Name (First, Middle, John B. Russe)							2. Date of De. Month	ath Day	Year	3. Time of Death	
	/Media	cal			6 l	45 000 7			<u> </u>	June	0.0	2005	7:05 AM	
	Examir	ier	4a. Facility Name (If not institution, St. AGNES IT		Der)	4b. City, T		Location			4c. C	ounty of Death		
	Funeral				. Age (In yrs. last birth	day) If Under	1 Year	If Under	24 Hrs.	B. Date of Birt	h	9. Birth	place (State or Foreign	
	Director		219-05-9466	1⊠M 2□F	85 Y	s. Months	Days	Hours	Min.	(Month, Da) une 26		Cou	ntry)	
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits	
	f sho	ō	Maryland Baltin	nore		sville							1 ☐ Yes 2 💆 No	
	r 28e-	Director	10e. Street and Number		0.000	10f. Zip (	Code				10g. Citize	en of What Cou	ntry?	
	th with		313 Lambeth Road	ł		21	228				USA			
	ems ems	Funerai	11. Marital Status		ent Ever in U.S.	13. Was Decede		spanic Orig	gin? (Spec	ify Yes or No		Race - Ameri Black, White,		
36	s afte	by Fu	1 Never Married 2 Marrie 3 Widowed 4 Divorced	d 1 (XYes :	WWII	1 ☐ Yes 2				,			ite	
5-0036	72 hours after death with the Maryland natural, or items 23a or 28e-f show disal Examinat must be indiffed at	ed b	15. Decedent's	102.0.02		ecedent's Usual	l Occupa	tion				of Business/In		
215	within 72 ene. then ne	Completed	(Specify only highest Elementary/Secondary (0-12)			Give kind of work ife. DO NOT use	k done d	urina most	t of working	9	TOD. TRITE	01 003111033/11	destry	
21	filed with Hygiene other the	E O	Lienteriary/55000 roary (5 12)	5+		orney					U.S.	Gover	nment	
Maryland 2121	d ta b	Be	17. Father's Name (First, Middle, La							(First, Middle,	Maiden S	umame)		
3	should nd Men marke umaric	10	John Manning Rus							Flynn				
Ma	d 2 si th and treur		19a. Informant's Name/Relationshi		00.0	Mailing Address						100 5-1	Letter - Carrier	
	Heelth Heelth tem 27 other tr		Mary E. Russell 20a. Method of Disposition	WJ	20b. Place of F	3 Lambe Disposition (Name	a of	1	Cato	nsvíll te	20c. Loca	ryland ation - City or To	21228 own, State	
Ę	Pages nent of int: if it		1 XBurial 2 ☐ Cremation 3 3 4 ☐ Donation 5 ☐ Other (Spe			crematory or other ne Park			une 6	,2005	Wood	lawn. M	faryland	
Baltimore,	permit. Pages 1 an Department of Heel Importent: If item 2 any injury or other once.		21. Signature of Fundal Service Li	199	11	22. Name and	Addres:	1						
8	88 5 8		21. Signature of Funcial Service Licenses of Facility Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Avenue; Catonsville, MD 212											
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that canly one cause on ea	used the death. Do no ch line.	t enter the mode	of dying	, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ aA	SPIKAT	200	P	سیر	mo.	V,1			Onset and Death	
	/Medical Examiner		resulting in death)	Due to (c	r as a consequence of	):		-						
0	7	er	Sequentially list conditions if any, leading to immediate	b. Due to (c	r as a consequence of	BEAIN	EAIN GLIUMA						1 YEAR	
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events											
ó	sicien and burial-transit	Exa	resulting in death) Last	Due to (c	r as a consequence of	:								
8760,	P S	dicai	•	d										
9	ertific Jing p	Mec	IF FEMALE:	02- 11			- 07.00							
Вох	death certifics attending plant of for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bir	ome of pregnancy th 2 Fetal death nt at time of death	3 ☐Ectopic pre 5 ☐ Other (spe					23	<li>d. Date of delive Month</li>	ery Day Year	
o.	that the de led by the detached	nysic	1  Yes 2  No 9  Unknown	9☐ Unknov		5 ☐ Other (spe	city)							
s, p	res that igned b be deta	by Pr	Part II. Other significant condition	s contributing to dea	ath but not resulting in t	he underlying ca	use give	n in Part I.		23e. Did to	obacco use	contribute to the	he cause of death?	
rds	quire an sig									1 🗆 ነ	′es 2. 🗷	No 3 □ Prot	ably 4 □Unknown	
Record	e law requ has been je 2 shouk	Completed								24a. Was		24b. Were auto	psy findings available mpletion of cause of	
E E		E O								perfo	rmed2 2 No	death?	22No	
Vital	Physician: The this certificeteral director, pag	Be (	25. Was case referred to medical examiner?		/				of Death (	Check only o	ne)			
of \	shys this al dii	은	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 In	patient 2 ER/Outp		_	4 🗀 140				Other (Specif	y)	
	9	tion	1 ■Natural 5 □ Pending	(Month	Injury 28b. Tin , Day Year) Inju	iry M	c. Injury Work 1 □ Y	at ? ′es 2.∐1		3d. Describe h	iow injury	occurred		
Division	of or Attending efter death. Director: After din by the fune	Certification:	3 Suicide 6 Could no	t be 28e. Place of	of Injury - At home, fam					3f. Location (S	Street and i	Number or Rura	al Route Number,	
ă	i Si fie	Serti	4 Homicide	buildin	g, etc. (Specify)					City or Tou	m, State)			
	To the Hospitel or within 24 hours efter To the Funerel Direction completely filled in I	Medical (	29a. Certifier 1 Certifying (Check only one) 2 Medicel E	Physician: To the la cominer: On the ba	pest of my knowledge, sis of examination and/ er stated.	death occurred a or investigation, i	it the time in my op	e, date and inion, deal	d place, an	d due to the d	cause(s) ar date and p	nd manner as s lace, and due to	tated. o the cause(s)	
	To the To the Comp	ĕ	29b. Signature and title of certifier	- 1	//		License					signed (Month,		
•			Ille 1		Min	1	200	205	8-44	/ -	×0/	UE 2,	2005	
	INT		30. Name and address of person w	no completed cause	of death (Item 23a) (T								25	
	( ,		31. Date filed (Month, Day, Year)	200 0	gistrar's Signature	10 6	31	- 77/	MUR	-, 1.	20	2125	9	
State 31. Date filed (Month, Day, 1947) 32. Registrar's Signature 32. Registrar's Signature 33.														

State of Maryland / Department of Health and Mental Hygiene 1 - State Registre Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** May  $3\overline{1}$ 2005 MAGALY RODRIGUEZ-ALONSO 5:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8712 Colesville Road, Apt #409 Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Aug. 19, 1 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🖺 F 56 216.50.7970 Director Cuba Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 Is marked other than "naturel", or Items 236 or 286-1 show other traumetic event, the Modical Express, must be notified at 1⊠Yes 2 No Directo Maryland Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20901 8712 Colesville Road, Apt #409 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. snt: If item 27 Is marked other than "naturel", or Itel 1 ☐ Never Married 2 ☐ Married ☐Yes 2XNo Baltimore, Maryland 21215-0036 1 X Yes 2 No Specify: Cuban If Yes, Give Year or Dates: Specify: White þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) N/A None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Portilio Rodriguez-Alonso Enriqueta Rodriguez-Alonso Manue 1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Danielle C. Schaffrath/daughter 1443 Harding Lane, Silve Spring, Maryland 20905 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Deportment of H Importent: If ite any injury or ot once. cemetery, crematory or other place. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State etro nematory ' 4 □ Donation 5 □ Other (Specify) 21. Signatur of Funeral Pervice License 22. Name and Address Facility 18434 23a. Part. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each list immediate Cause (Final disease or condition resump in death) Do not enter the mode of dying, such as cardiac or respiratory arrest A ximate Interval Between Onset and Death iabeta Physician Yens /Medical Due to (or as a consequence of) **Examiner** 0/5/12 Man 4045 Sequential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner requires that the death certificate be executed the burial-transit that initiated events ettending physician and for use as the burial-traresulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Dav 4☐ Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 W Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 X No Division of Vital To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Injury at Work? After t Natural 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No investigation М 2 Accident the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier within 24 ho To the Fune completely fi and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number teenstille June 3, 2005 D43496 h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohammad Khalid, M.D, 8630 Fenton Street, Suite #700, Silver Spring, MD 20910 32. Pogistrar's Signature 31. Date filed (Month, Day, Year) State 7 2005 Registrar